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Religion and health: the public intervention of Catholic religious agents trained in bioethics in the parliamentary debate on death with dignity in Argentina

Religión y salud: la intervención pública de agentes religiosos católicos formados en bioética en el debate parlamentario sobre la muerte digna en la Argentina

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ABSTRACT This paper discusses from a sociological perspective one of Catholicism's fronts of public intervention in the development and enactment of health legislation. In particular we analyze the debate in parliamentary committees on the so-called "death with dignity" law (No. 26742), for which a group of bioethics experts was convened to counsel senators regarding the scope and limits of the law. The majority of the invited experts advocated a personalist bioethics perspective, which is a theological bioethics development of contemporary Catholicism. In the debate no representatives of other faiths were present, reinforcing the widely studied overlap between Catholicism and politics in Argentina.
KEY WORDS Religion; Catholicism; Health Legislation; Right to Die; Bioethics; Argentina.

RESUMEN Desde una perspectiva sociológica, este trabajo aborda una de las aristas de la intervención pública de ciertos sectores del catolicismo en la elaboración y sanción de leyes de salud. En particular se hace foco en el debate en comisiones parlamentarias sobre la llamada ley de "muerte digna" (Ley 26742) en el cual se convocó a un grupo de expertos en bioética para asesorar a los senadores sobre los alcances y límites de la ley. La mayoría de los expertos invitados pregonan la perspectiva de la bioética personalista, un desarrollo teológico de la bioética del catolicismo contemporáneo. En el debate no participaron representantes de otros credos consolidando la ampliamente estudiada imbricación entre el catolicismo y lo político en Argentina.
PALABRAS CLAVES Religión; Catolicismo; Legislación en Salud; Derecho a Morir; Bioética; Argentina.

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INTRODUCTION

This article discusses how the authentication of the political decisions is materialized in a process of debate and legislative discussion by resorting to scientific and bioethical experts as a stage capable to settle possible conflicts of interests[1] in Argentina. It is based on this expertise that experts in bioethics are called on as scientific scholars in various parliamentary committees. This is one of the aspects of the public interventions of religious agents[a] in Argentina. The purpose of this article is to also contribute to the development of the recent sociology of bioethics proposed by Raymond De Vries,[2] and the sociology of bio-knowledge developed by Alan Petersen.[3]

We will approach here a parliamentary discussion about death with dignity held in 2011 in Argentina. The debates in the legislative committees are significant because, there, bills that may be put into consideration (or not) in both houses of the congress are drafted. In the last few years, these debates have become more noticeable and they have now taken the form of "public audiences" in which different parties try to impose their own views. The law represents for some people a reassurance that society is in fact "their society," the meaning of the law is "their meaning," and the moral of the law is "their moral."[4] What is at stake in this public intervention is the redefinition of a certain number of boundaries, especially in medicine and society, what is normal and what is not, and the limits of the human body. The intention here is to transform the elementary categories by which individuals are defined, as well as the relationships established among them: forms of sexuality, the edges of life and the limitations of human beings.[5]

We will deal with the parliamentary debate in committees on an issue related to bioethics, which has become relevant in the last years: death with dignity. The debate will be analyzed individually, paying attention to their *own* performance and staging. To understand the discussions that take place when legislators convene experts to legitimate bills, we will use some analytical categories designed by Erving Goffman.[6] These categories will help us organize the analysis and find common ground with other parliamentary debates in which bioethical expertise is required (non-punishable abortion, artificial insemination, among others). Although these debates deal with different topics and are carried out in different parliamentary houses, they all maintain and share a ritualistic scene. Thus, we will consider that the parliamentary debates are presented within a specific context, i.e. places where the encounters between the different social actors are held.[6] These *encounters* are the interaction between the individuals who attend to the debate. The context and the encounter constitute a space (a symbolic territory) which the agents strive to claim for themselves in their own interaction process[6]: the participants who attend the encounter to debate will seek to impose their legitimate point of view about the contents of the bills under consideration. Apart from analyzing the context and the specific encounters in which the experts in bioethics contribute their expertise to legitimate political decisions, we will provide some relevant data about what can be called the "pre-encounter," which can be defined as the information, data, and previous knowledge the experts in bioethics have before attending the encounter where they are called on to debate. This ranges from specific technical knowledge to the analysis of each bill in particular (along with the current political situation) and becomes the background that facilitates the debates and public audiences. Therefore, to analyze individually each parliamentary debate in committees, we will consider academic studies that illustrate the state of the art in the respective field. Then, we will present the key information the experts in bioethics handle before it is presented for parliamentary debate (the "pre-encounter"). Finally, we will analyze the context and the interaction between the experts in bioethics, the legislators (who introduce the bills), and some adversaries who are also experts, along with the central points of each debate. In this regard, a fact must be taken into account:

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the members of both houses consider themselves Catholics (at least 60%) and out of that figure a high proportion meets regularly with church religious leaders to discuss political and social issues.[7] Furthermore, most legislators consider that the participation of religious people in committees and bioethical issues is legitimate.[7] This situation that runs across both national and local parliamentary debates, helps framing the contexts and interactive encounters in anchored relationships between religious agents and legislators. Legislators convene the experts in personalist bioethics (laypeople and catholic priests) so as to obtain legitimacy for their political decisions. As we will see in each parliamentary debate in particular, the point here is not a simple strategic intervention as a way to co-opt these experts in bioethics into a space that is expected to be secular. On the contrary, in most of the cases, they are convened by the legislators themselves to give technical advice:

> The people invited to the debate about death with dignity. Let's see. Father Andrés, Father Rubén, a lawyer from the Conference of Catholic Bishops of Argentina [*Conferencia Episcopal Argentina*]. Father Andrés knows a lot about these subjects, about bioethics. Other people invited? I do not know yet. The list only includes those I mentioned to you. This was organized by the senator who introduces the bill. If you want to come, write me an email because, in fact, this is not a public audience; this is a plenary session of committees. You can come in and take a look. You may be invited to talk but a senator will speak for you. (Administrative personnel of the health committees of the National Senate, telephone communication, September 14, 2011). [Own translation]

Experts are invited in response to a characteristic goal of contemporary societies: very important conflicts are solved in an apparently neutral way[8] resorting to scientific legitimacy for political decisions. The religious agents attend the debate as experts in bioethics on an equal footing (because their prestige is recognized) with other experts in bioethics or disciplines related to social problems that are being discussed and require a decision. In this way, they take part in the institutional framework of public intervention,[9] where technical knowledge and expertise are mobilized to be inserted in political agendas. It is a process in which the exercise of power in contemporary societies is imbued with knowledge about the nature of the issues the government intends to rule and administer: the body of the individuals.[5,10] Here we will deal with the way these religious agents, experts in bioethics, step into the parliamentary scene to discuss matters related to death and the way Argentines die. We will analyze the debate of the plenary meeting of the committees of health and sports, budget and finance, and general legislation on September 27, 2011 in the Senate about the Act Nº 26742 on death with dignity, which after the debates would be passed by unanimous decision by the Senate on May, 2012.

ABOUT THE RESEARCH

The research that has inspired this article was conducted for five years within the development of the doctoral thesis "Bioethics and Catholicism: training and public interventions from personalist bioethics in Argentina (1999-2012)" [*Bioética y Catolicismo: entrenamiento e intervenciones públicas desde la bioética personalista en la Argentina (1999-2012)*]. The purpose of the thesis above was to address the problem of how religious agents instructed in bioethics in Argentina intervene in the public area through their performances, careers, and specific training. The analytic perspective adopted is inserted within the scope of the interpretative paradigm of the social sciences,[11] and the sociological tradition,[12] specifically the sociology of Catholicism or "The" Catholicisms.[13,14]

The research was organized around two aspects, which came up from categories built in the fieldwork itself: the training to determine the *bioethical expertise* and the

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public intervention. In this regard, some strategies were combined: a) active observation in areas of bioethical training (expertise) and public intervention (parliamentary health committees); b) documentary analysis of written sources; and c) interviews to trainers and those who are trained and then intervene in the public area (parliamentary health committees and/or public hospitals).

Regarding the active observation, four postgraduate courses were observed (seminars, specializations, or Associate's degrees in secular or religious universities ruled by religious agents trained in bioethics; those who took the course had privileges over those who passed the exams and had the certifications of the courses): a Postgraduate Associate's degree in Clinical bioethics (Universidad CAECE); a Course of Family Planning (Universidad Católica Argentina); a Postgraduate in Bioethics and Human Rights in Latin America (Universidad de Buenos Aires, Faculty of Social Sciences); and Bioethics Committees (Universidad Católica Argentina). Eight conventions about bioethics were held during eight days, out of which 62 conferences were observed by experts in bioethics. The aim of the active observation was to know the process of instruction, training, and acquisition of *bioethical expertise*, which then enables participants to take part in the public debates as expert advisors. The researcher always introduced herself as a student of the doctorate in Social Sciences of the Universidad de Buenos Aires, where she was working on her thesis about the relation between bioethics and Catholicism in Argentina. When the thesis was finished, a public invitation to its public defense was sent; some professors of the postgraduate courses took part and one of them was chosen by the Doctorate Committees as jury.

This article will make no mention of the findings obtained in the research study regarding the analysis of the postgraduate instruction courses and conferences. We will just mention that the training within the scope of the Kentenich Committee, both in the conventions and postgraduates courses, stood out as one of the spaces of greatest number of Catholic and non-Catholic participants, where science and religion are brought together in an articulated manner. The committee does not favor an orientation that seeks to find a problem-solving method of easy application but it favors an integrated training proposal with abundant theoretical material in philosophy and anthropology (as well as medical and legal material). According to Elena Lugo, Director of the committee, its theoretical and epistemological proposal combines the personalist anthropology with the work of Elio Sgreccia and the methodological perspective of the organic thought of José Kentenich, founder of the Apostolic Movement of Shoenstatt (work field data).

Parallel to the training in postgraduate courses that provided guidance in the socialization process of the experts in bioethics, active participation was performed in the parliamentary health committees, which were one of the favorite areas of public intervention of the *bioethical expertise* (both secular and religious). The committees were as follows:

- Non-punishable abortion: public audiences of the health committee of the Congress of the City of Buenos Aires, October 31, 2008, and analysis of shorthand versions of the sessions of October 3, November 14 and 21, 2008.
- Artificial insemination: Debates in the Health and Social Action Committee on September 1, 2009 and analysis of shorthand versions of August 11 and September 1 and 29, 2009; public audience about abortion in the Honorable House of Deputies of Argentina, July 13, 2011.
- Death with dignity: Plenary meeting of committees about "death with dignity" in the Honorable Senate of Argentina, shorthand version of September 27, 2011.

Regarding the documentary analysis, the participants worked with 525 sources, including 112 documents of the Catholic Church (encyclicals, papal statements, magisterium); 47 journalistic sources (secular and religious); 110 documents of international organizations,

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government departments, medical associations, and rules that regulate bioethics; 48 documents of Argentine universities (public and private) such as programs of study with bibliography and certificates of careers issued by the National committee of University Evaluation and Certification [*Comisión Nacional de Evaluación y Acreditación Universitaria*]; 102 presentations published in the records of conferences about Bioethics in Argentina from 1999 to 2012; and a selection of 106 academic articles on bioethics taken from scientific journals in order to trace the main debates on the discipline and its mythical origins in the North American context. Finally, 127 articles and chapters from academic books by Latin American authors were analyzed. These authors attempt to give epistemological support to bioethics and discuss its historical origins in the region.

Concerning the interviews, held almost at the end of the work field in order to get deeper into the aspects that could not be analyzed through observation (as in the case of the public hospitals committees), 42 members of the bioethical committee were interviewed by means of an anonymous questionnaire: 27 physicians, three psychologists, two lawyers, two philosophers, two male nurses, one sociologist, one biochemist, one bioengineer, and one anthropologist (three preferred to keep their professions secret). Half of them were women. The average age of the interviewees was 56 years (between 37 and 76). They belonged to different regions of the country (Provinces of San Juan, Río Negro, Córdoba, Chaco, Corrientes, and Buenos Aires except for the metropolitan area). However, most of them belonged to Greater Buenos Aires. The interviewees were contacted at the symposium of hospital ethics in the City of Buenos Aires. Everyone was given the opportunity to talk to the researcher or answer questions in writing. Most of them preferred the latter because in this way they remained completely anonymous. Finally, nine key informants were interviewed in depth (it was done orally and recorded on tape, excepting for one case in which notes were taken): three professors, who were responsible for bioethical areas in public universities, one member of the House of Deputies in the Health Committee, two priests, members of the bioethical committee, one representative of the Universidad Catolica Argentina (UCA), one president of the bioethical committee in a public hospital, and one lawyer who was also a lecturer and member of committees of bioethics.

From all the corpus of the research study conducted to understand the relationship between bioethics and Catholicism in Argentina, we will focus on one aspect of the *public intervention*: the exceptional counsel of the religious agents trained in bioethics provided to the persons whose duty is to pass bills regarding health, in this case national senators. We will not recapture the voices of senators, but the voice of the experts who were convened to give counsel on the text of the law. We will focus on the plenary meeting of the committees that had impact on the process of the enactment of the law about death with dignity, in November 2011. Furthermore, we will also recover some testimonies and extract of interviews or communications with key informants after the event in question that will help us have a holistic comprehensive frame.

We need to explain that throughout this article, we try to avoid the use of the words "Catholic Church" to refer to the intervention of the religious agents who recognize themselves as Catholics because we cannot state that through their actions they are officially "representing" the church they belong to. Following Giménez Béliveau,[14] we prefer to use the word catholicisms, in plural, to refer to that group because it expresses the heterogeneity and diversity of their faith. Furthermore, the public intervention to pass laws on bioethical issues is not an exclusive action of the catholicisms; other faith expressions also take part in these matters. However, national senators decided that only Catholics participate in this particular debate about death with dignity, as we will see later in the article. Therefore, the hypothesis which guided the research that gave support to this article states that there are different ways of public

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intervention by faiths in Argentina, with bioethics being a privileged arena for these actions. The course of research studies connected to other religious groups has barely begun and it has been developed with the project "Religion and health: Trajectories, representations and ways of intervention in the public area of religious agents trained in bioethics (2014-2016)" ["*Religiones y salud: Trayectorias, representaciones y modos de intervención en el espacio público de agentes religiosos formados en bio*ética*" (2014-2016)*], financed by the National Agency of Scientific and Technological development [*Agencia Nacional de Promoción Científica y Tecnológica*] (PICT-2013-2541).

THE DEBATE ABOUT DEATH WITH "DIGNITY"

In the last few years in Argentina there has been an increase of public debates about the refusal of medical treatments or means that prolong life in an artificial way on people with terminal disease, persistent vegetative state, or brain death.[b] Generally, these issues take public relevance when a particular case causes a shock in society. In August 2011, one case became widely known: a girl whose family requested to disconnect her from a respirator. This case made possible and accelerated the parliamentary debate and the law that was passed afterwards, called "death with dignity." Section one establishes the "free will" of individuals to reject treatments that prolong life in an artificial way.[17] The Argentine press published daily articles about the case of this child; 932 pieces of news from the national written press were published and a good number of television reports were broadcasted. Furthermore, different renowned people from political and judicial areas gave their opinion publicly about the case.[c]

These debates, which have become more noticeable to the general public in the last few years in Argentina, are part of a global process in which modern societies discuss medical proceedings in the final stage of people's lives and general notions about death with dignity and "good" death.[19] The representations regarding death with "dignity," "natural" death, and "good" death, which are notions historically contextualized and arranged, have influence on the everyday proceedings involving death in hospital wards. Since the mid sixties, a significant number of research studies about death in modern societies have been conducted.[20] Sociological works stand out, for they take the hospital and the interactions of patients with health professionals, gather different courses of death, strategies of the hospital personnel to deal with patients who are at the end of their lives and the organizational contexts that form the process of death, which is seen more as a social phenomenon than just as a physiological event.[21-25] Furthermore, changes in the conception of death in the Middle Ages and in modern times were analyzed from a historiographical point of view. The Middle Ages is characterized as an era when death was public and common (more or less traumatic); in modern times, on the contrary, death is privatized, "captured" and it becomes a death intervened by medical techniques.[26-28] There has been an increase of research studies which reveal that deaths in hospitals, intensive care units, and palliative care in hospitals and hospices have been on the increase.[29,30] Some issues have been studied, such as religious expectations and the secularization process by means of the analysis of cemeteries, death rituals, religious writings, and the technical expertise of palliative care.[27,30,31-33] In addition, there is a great deal of works in bioethics and medicine that discuss the appropriate or inappropriate training of health professionals to deal with the issue about the final stage of patients' lives.[34-38] Finally, a group of researchers set out accurately what biological death and terminal illness really mean presently (brain death, coma, persistent vegetative state) and the ethical dilemmas involved, such as, for example, euthanasia, assisted suicide, living will or advanced healthcare directive, palliative sedation and suspension of treatments.[15,16, 39,40-43]

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Without taking into account the actions effectively carried out in hospitals involving death,[19] the debates revolve around deciding from a legal framework on the meaning of "death with dignity" and euthanasia. While some countries have regulated the practice of euthanasia and assisted suicide,[43-45] others consider these a crime.[42] According to Simón Lorda's analysis[46] within an Iberoamerican context, the juridical discussion regarding death has been constant since the 1930s, and it has been influenced by the texts of professional ethics of medicine written by members of the ecclesiastical hierarchy of the Catholic Church.[d] In this regard, we could state that the participation of religious agents in the discussion over legal and juridical areas regarding death has remained constant throughout history.[46] This is repeated in the debate on September 27, 2011 in the Senate of Argentina, as we will see next. The presence of priests and experts in Catholic bioethics was not considered problematic by any of the senators. When dealing with death, it is expected that Catholic theologians express themselves (representatives of other faiths were not invited). Before starting with the debate and the direct public intervention of the experts in (Catholic) personalist bioethics, we will analyze the previous data the religious agents relied on to participate in the debate. Such data constitute what we have called the "pre-encounter" of the interaction.

THE "PRE-ENCOUNTER"

Although the parliamentary debate was intensified during 2011 in order to pass the Act Nº 26742, in May 2012, bills on death with dignity, ends of treatments, living will, and palliative care can be found in the records of the legislative houses since 1997. It took about fifteen years to pass a law that guarantees the respect to individuals' autonomy in the process of death. What characterized the last period (2011-2012) was the great deal of agreement between the political forces when passing the law in record time for the standard of parliamentary proceedings. Six bills were introduced at the same time at the beginning of 2011 in the House of Deputies.[47-52] By November, in a combined meeting of the Committees of Social Action and Public Health, General Legislation, and Assurance of Human rights, all the bills were unified by a combined ruling. Later on, it was recommended that the unified bill would be moved to the Senate in order to be evaluated in committee and then passed.[53] The text passed by the House of Deputies, which then had to be legitimated or not by bioethical experts in committee in the senate, contained this definition about the autonomy of the will:

> The patient has the right to accept or refuse certain therapies, or medical or biological proceedings, with or without expressing motives. They can also subsequently revoke their manifestation of will [...] Within the scope of this power, if any patient who is irrefutably informed that they are in the final stages of a fatal disease or suffer from an irreversible or incurable disease or suffered injuries so that they are in such conditions, they have the right to manifest their will to refuse surgical proceedings, cardiopulmonary resuscitation, or withdrawal of life support measures when these cause excessive suffering or are extraordinary or disproportionate compared to the prospects of improvement. The patient may also refuse hydration or nutrition when the sole effect is the extension of time in such irreversible or incurable terminal stage of the disease.[53] [Own translation]

The only disagreement with this definition was stated by three members of the House of Deputies: Julián Obiglio, whose uncle, Dr. Hugo Obiglio, was an academic of the Pontifical Academy for Life [*Academia Pontificia para la Vida*]; Juan C. Vega and Carlos Favario. They all expressed their refusal to the suspension of hydration and nutrition treatments. According to the doctrine of the Catholic Church and the Personalist bioethics theorists, it is not legal to withdraw nutrition and hydration to individuals

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suffering from a terminal disease or even in a permanent vegetative state.[54,55] Julián Obiglio accounted for his disagreement with the law:

> The references that authorize the patient to refuse nutrition and hydration, considered in Sections 1 and 2 of the amendment introduced, must be eliminated because they do not coincide with the concept of death with dignity, which implies the right to die in a natural way, i.e. the end of the life cycle; but this concept of death with dignity is not related in any way to death by induction or artificial delay of death. Nutrition and hydration are not odd things to the natural way of living of human beings. Drinking and eating are not artificial. If someone is not fed and not hydrated, we would bring about euthanasia by omission. We cannot say that nutrition and hydrating a terminal patient is a disproportionate way of keeping them alive. If nutrition and hydration are the only two things that keep a patient alive, then it means that no other measure is being performed to keep their life. Therefore, we would not have in these cases therapeutic obstinacy, which is, on the contrary, a medical practice condemned by the rule.[53 p.3] [Own translation]

The authorization to stop hydration and nutrition on patients in terminal stages arose concern and apprehension in the members of the local ecclesiastical hierarchy and the experts in bioethics. They made great efforts to take part in the debate, as José Mollaghan, the archbishop of Rosario, says:

> As the distance between the positive law and the natural principles increases, we, men and women of faith, must reinforce our training and knowledge on such issues not to enforce the law consciously, because the positive law cannot change such principles [...] In this regard, the Letter of the Health Agents and other qualified commentaries say: "Hydration and nutrition, even when administered artificially, are part of standard treatments that have always been provided to patients when such procedures are not harmful for them. Their wrongful withdrawal means a real and deliberate euthanasia." It is morally illegal to stop providing these ordinary and elementary means. This would constitute negligence, as in the case of other ordinary means, for example, the caring of the body of the diseased; because any person of any condition has the right that their life be respected and kept as long as possible by means of the administration of ordinary means. If these are denied, then we would not have a death with dignity, and the diseased would not die in peace.[56] [Own translation]

Once in the National Senate, the passed bill would have to be contrasted with the proposals of some senators about death with dignity. In this regard, a plenary meeting was organized; the Committees of Health and Sport, General Legislation, Budget and Finance, and Labor and Social Care took part. The legislator who chaired the encounter was senator Cabanchik, ex Director of the career of Philosophy of the Universidad de Buenos Aires and researcher of the National Scientific and Technological Research Council (CONICET) [*Consejo Nacional de Investigaciones Científicas y Técnicas*]. He had his own project about the exercise of people's rights in the process of their own death.[57] The meeting included the analysis of the projects of other senators about life will and palliative cares.[58-61] They had to reach an agreement concerning these projects, putting them on a comparative basis with the text of the law passed by the House of Deputies in order to formulate a joint ruling that could be considered by the Senate as a whole. The projects contrasted in the House of Deputies and those on which the senate worked had both more agreements than disagreements. On the one hand, all the participants in both houses indicated that individuals should receive true information about their health condition in the terminal stages of a disease in order to be able to make decisions about what to accept or refuse. The legislators agreed on considering "natural death" beneficial to the population, i.e. a death that is not intervened by medical techniques. On the other hand,

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there were disagreements about which treatments were considered "not natural" or "artificial." Therefore, in accordance with the Catholic doctrine, some of them proposed keeping hydration and nutrition[50,58]; the rest proposed the possibility to refuse them on the basis of individual autonomy. This was the only issue that brought about controversy, although, finally, Section 1 was passed, which made possible the refusal of hydration and nutrition.[17] We have seen so far from the background on which the direct public intervention of the experts in personalist bioethics was carried out regarding death with dignity. With all this information and the law passed by the House of Deputies, plus the legislators who had similar projects and a definition of death connected to the doctrine of The Catholic Church ("natural" death), the experts attended the National Senate to legitimate (or not) the legislative texts. We will see next the dramatic display of the debate.

The context and the encounters

Unlike other parliamentary debates such as those about artificial insemination or non-punishable abortion, only one meeting was proposed to discuss this topic: 18 experts and one guest (not a specialist), who told her experience with a relative, attended the meeting. Philosophers, physicians, lawyers, and psychologists attended as experts in bioethics. Most of the experts were specialized in medicine and law[e] and they performed their professional activities in public institutes (universities and hospitals). Among the participants who could be placed in the "religious" group, there were two priests, a consecrated layman, a representative of the Argentine Catholic Lawyers Association, and a lawyer, ex tutor of embryo freezing of the City of Buenos Aires. They were five Catholic experts in a total of 18 guests. The rest of the specialists, except for the director of bioethics of Latin American Social Science institute (FLACSO) [*Facultad Latinoamericana de Ciencias Sociales*], belonged to different institutions and the arguments they put forward in the debate were suitable for the experts in personalist bioethics.[62]

The *context* in which the encounter between legislators and the experts invited was planned was the hall where important events are usually held by the Senate. This place is not a common commission meeting room. The Manuel Belgrano hall is an auditorium that has a stage, a lectern for speakers and stands, as a theatre, for the audience and the press. This deliberative process was organized on a stage where speakers had ten minutes to present their ideas. As the experts had the floor, we realized that it was not the first time that they were part of this type of event. Their expertise has been mobilized in other occasions, to legitimize the process of passing laws in parliament. The words of the only newcomer to the Senate illustrate this situation:

> How are you? I'm in tears already. A friend of mine just came and she made me weep from the beginning. This is hard! Ok, I'll introduce myself. My name is Sofia. I'm a journalist. I've been working for many years, the Congress included, covering these issues. I've never been on this side of the stage and I think the lectern is not very good because it puts a certain distance between us that I hope we can shorten through my speech. Interviewing Senator Cabanchick, precisely, about the initiative of a bill on death with dignity, I had the chance to tell him about my case. My little sister's case. The truth is that it is so natural to me but when we finished talking he opened his eyes widely and told me to come here to tell you about my sister's case. And well, here we are. I said yes. I played the wise woman. I thought this was going to be easy. I didn't sleep last night. I realized that it was not easy at all. Maybe, through my sister's case I can help you with this issue, because, currently, we've managed with my family to avoid reaching the point of having to decide whether to remove the respirator from her or not. (Sofia, committees plenary meeting, Honorable Senate of the Argentine Nation, September 27, 2011). [Own translation]

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The other speakers, experts, thanked the senator who had convened them for the invitation and then had the floor to present their main arguments. The dialogue between the president of the meeting, Senator Negre de Alonso and the secretary priest of the Health Pastoral of the Argentine Catholic Bishops Conference (2011) showed his familiarity with the parliamentary sphere:

> Mr. Chairman: Now, the priest, executive secretary of the Catholic Bishops Commission for the Health Pastoral of the Argentinian Catholic Bishops Conference will have the floor.
> Mr. Priest: Good afternoon, everyone. I am Edmundo's nephew, who died. An uncle, who was senator of the province of San Luis in 1966 and died on July 17.
> Ms. Negre de Alonso: In addition, he was an important historian.
> Mr. Priest: My uncle was very important, and my godfather. My name is Edmundo because I was named after him. In addition to being at the Catholic Bishops Conference for thirteen years as a hospital priest, I spent six years working at the Muñiz Hospital and I have been working for eight years at the Alvarez Hospital of the City of Buenos Aires, in Flores. (Committees plenary meeting, Honorable Senate of Argentine Nation, September 27, 2011). [Own translation]

The director of the Institute of Bioethics of the Universidad Católica Argentina (UCA) also set out from the beginning that he was not a newcomer to this debate:

> I thank you very much for the invitation. We already have had the pleasure of sharing these ideas with some of you. In this first part I am simply going to set diverse general opinions and I will not deal explicitly with the analysis of the bill [...] Accordingly, our proposal, which we have repeated in many other debates, is more a technical matter referred to the team of treating physicians, related to the proportionate or the disproportionate, which has to do with the futility of the means. In other words, if it is considered that the means to be used will provide the patients with the possibility of recovering, or if they will not have any chance to recover their autonomy. (Representative of the UCA, committees plenary meeting, Honorable Senate of the Argentine Nation, September 27, 2011). [Own translation]

Religious agents who attended the debate, all of them experts in bioethics and in position of authority in the local hierarchy, planned a deliberative strategy in which most of them presented their ideas in technical terms (legal-medical-bioethical) and only one of them played the role of a religious person ("The Father"), referring to religious matters about death[f]:

> And this must lead us to think about [...] the purpose of humankind regarding life, friendship, work, effort, human love, parenthood, life, death; for believers: the matter about God and eternal life [...] and when you walk through the hospital and you are with patients or someone approaches you and says, "Father, is it wrong if I ask God to let my Dad die, because he has spent two months in the intensive care unit?," "Is it wrong that I ask for the death of my wife who is dying?," and sometimes they live with a sense of guilt. It is true that for believers God has the dominance of life: God gives life, God takes life, but these medic mediations are in the middle. As a friend of mine said: "I do not want physicians to die, I want death itself [...] Thank God, there are hospitals that have therapeutic equipment, religious service but we must not be afraid to talk about death. I often talk to patients about death: How was your life? How did you live? How would you like to die? What do you think there is going to be after life? Do you think about heaven? Who will receive you? Who is waiting for you? But we must also support the family, the family that is in need. And often, hospitals are not prepared to do so. There are chaplains, priests, volunteers that try to support families. (Priest of the Argentine Catholic Bishops Conference, committees plenary meeting, Honorable Senate of the Argentine Nation, September 27, 2011). [Own translation]

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A detail, which may seem anecdotal, illustrates the place of scientific and academic credentials to legitimize the arguments presented. All the presents had an academic curriculum that guaranteed their status as bioethicists to participate in the debate. However, only one of the guests had the scientific credentials issued by the National Council of Scientific and Technical Research (CONICET) [*Consejo Nacional de Investigaciones Científicas y Técnicas*] and this put her in a place of symbolic superiority over the others. The expert, in addition to being lecturer at several universities and researcher at the CONICET, was president of the International Association of Bioethics and adviser of the United Nations. She was the only one of all the presents that was not introduced with her curriculum by the chairman of the parliamentary meeting. Her name was Florencia Luna, director of the area of Bioethics at the Latin American Faculty of Social Sciences (FLACSO) [*Facultad Latinoamericana de Ciencias Sociales*]. She was introduced in the following manner: "We will call physician Florencia Luna. Physician Luna has been invited by Mr. Senator Cabanchik" (committees plenary meeting, Honorable Senate of the Argentine Nation, September 27, 2011).[g] This situation left a mark on the subsequent debate.

From the local personalist bioethics point of view, the theoretical position developed by Florencia Luna in her works is considered theoretically adversary, linked to moral liberalism and "gender ideology" (Expert in bioethics at the Universidad Católica Argentina, interview, September 12, 2011). In addition, it is not mentioned in any manual as one of the lines of bioethics developed in Argentina[63] and it is not considered as a possible perspective with which to build bridges. The priest, expert on personalist bioethics, who was interviewed a while after his speech in the parliamentary debate, where he took up the role of a religious person, illustrates this perception:

> At FLACSO, with Florencia Luna, who is a serious and educated woman. And yes, she teaches principlism ethics. I... For example, this is a flaw that I see in Florencia Luna; she is an expert in bioethics at university meetings, framed in diverse currents: gender, women... (Priest of the Catholic Bishop Conference, interview, September 17, 2012). [Own translation]

This perception also works as a dominant representation in the background of this debate since we can find points of agreement with the rest of agents, experts in personalist bioethics, but not with the perspective of FLACSO, which is considered as a theoretical boundary.

Up to here, we have seen the context of the experts' interaction characterized by the familiarity of them in this area. In addition, we have presented information that illustrates how the legislators invited these experts to participate in the debates and how, despite the participation of bioethicists from different institutions, the gathering of religious bioethicists showed hegemony of values and representations of Catholicism in this debate. This is evidenced not only by the exclusion of representatives of other faiths in the debate but also the topics discussed in this debate, as we will see next.

MAIN TOPICS: EUTHANASIA AND CONSCIENTIOUS OBJECTION

The context of interaction to which personalist bioethics experts attended for discussion was evidence of the familiarity that they had with parliamentary spheres. In the first placer, whenever they attended a debate, they thanked those who had invited them and reminded them they had already discussed these issues on previous occasions and, in addition, they were confident and comfortable in an area which for newcomers, as the case of the woman who had a personal experience, was completely unknown and even somewhat hostile. Although the senators attempted to ensure a pluralistic debate by inviting 18 experts from different professional institutions and integrations,

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the fact that there were five personalist bioethicists and experts in other related matters tended to generate a debate that gave priority to Catholic representations and values over death.

In this regard, the deliberative process revolved around two issues. On the one hand, religious agents did not want that a law to allow euthanasia or assisted suicide in Argentina and, therefore, they put forward their arguments against the refusal of the suspension of nutrition and hydration. On the other hand, they were reluctant to incorporate to the bill a clause about conscientious objection. The text coming from the House of Representatives did not have this clause but the project of the Senator Cabanchik[57] incorporated a section about conscientious objection, individually for each professional, forbidding conscientious objection at an institutional level. In other words, if the individuals had taken autonomous and informed decisions, health institutions should ensure that a professional meets the wishes of terminally-ill patients. The problem of conscientious objection set out in institutional terms usually arises in cases of legal abortion, and allowing a law prohibiting this practice could be taken as a precedent for other similar cases. Act Nº 26742 was passed without making references to conscientious objection and it differed from the Catholic doctrine by allowing the suspension of artificial hydration and nutrition without considering it as a "passive euthanasia" or as a practice that enables "assisted suicide":

> Naturally, at the Institute of Bioethics at the UCA, we understand that the risk is between euthanasia and therapeutic obstinacy. I think the law is there to prevent both. The intention of allowing euthanasia is not perceived and of course, there is no intention of falling into therapeutic aggression either. My contribution to the topic as a differential element, because everything else is more or less similar, is the difference between hydration and nutrition. We still consider them, from the point of view of personalism, as elements that never fall within therapeutic obstinacy. (Representative of the UCA, committees plenary meeting, Honorable Senate of the Argentine Nation, September 27, 2011). [Own translation]

Diverse experts make a clear distinction between euthanasia and not euthanasia, and the whole debate revolved around this definition. Each of the experts expressed their opinion about this topic:

> I think there is only one euthanasia. Euthanasia is direct, active and voluntary. In any law the euthanasia must be well defined to avoid confusion. All the rest is not euthanasia, they are different ways to apply treatments or not. Any method used by an artificial mean is a medical treatment. If patients cannot be nourished by their mouths, whereas they are nourished by a nasogastric tube (ng-tube) or by a gastrostomy tube (g-tube), we can talk about a medical treatment; therefore, they can be limited as any other treatment. Both hydration and nutrition can be limited as mechanical ventilation. This depends on the decisions of the medical team, family or the patient. Regarding conscientious objection, I consider that there is no room for conscientious objection when it comes to the matter of death. Which physician would disagree with the idea of taking care of patients, relieving their pain, informing them and their family about their condition, treating them properly, giving a guaranteed health care and spiritual support at the end of their lives? There should not be a conscientious objection for that. The situation is different when we talk about other issues. We can keep a patient at an intensive care unit in a vegetative state for years. But is this life? What do we mean by life? We mean quality of life. Sometimes, prolonging life is not the same thing as prolonging death. And technology helps us to do things that are not exactly what we want to do. (Professor of Bioethics at the University of Buenos Aires, committees plenary meeting, Honorable Senate of the Argentine Nation, September 27, 2011). [Own translation]

In general, there were not many discrepancies in terms of the concepts presented,

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and after all these debates, the law would be passed almost without controversies. Despite the fact that "autonomy of the will" is guaranteed, there are diverse requirements that make this autonomy not so easy to perform. According to Section 11,[17] in order to accept an advance directive, it must be drafted before a notary public or a court of first instance in writing and in the presence of two witnesses. In addition, the decision of refusing the medical treatment may be revoked at any time. Thus, physicians can convince their patients to revoke their "autonomous" decisions. The closing of the debate by the representative of the Argentine Catholic Lawyers Association illustrates the level of agreement about when "to let a patient die," this is the only case in which there have barely been conflicts to pass a law:

> I think it's clear that, in essence, what we are looking for with this project presented by Senator Cabanchik is that all patients have a death with dignity, this is a circumstance that all of us naturally agree on. Just as there is a right to live, there is also a right that belongs to everyone, and in particular to a dying person, which is to have a death with dignity; the solidarity with the patients is essential. We cannot disregard the right to die with dignity of terminally-ill patients, in particular. There are several aspects involved in the exercise of this right, among which the most important aspect is the right to die with help of palliative medicine for terminally-ill patients, in a peaceful environment, in an atmosphere of serenity, where patients are with their loved relatives, and there is a nurturing relationship with the people around the patients, who are comforted spiritually, at peace with themselves and at peace with God as well. This right will not allow patients to produce their own deaths, not at all, this right will allow them to die peacefully and naturally when death comes, without anyone provoking it artificially and without useless or unnecessary suffering. A death with dignity arises from the greatness of spirit of who confronts it, and it gives patients the right to not to be object of extraordinary or disproportionate treatments that lead nowhere. In other words, no one can be forced to be at an intensive care unit with the only object of getting a precarious and pitiful prolongation of life. That is, health care that constitutes what has been called therapeutic obstinacy. All of this constitutes the right to die with dignity. Death is an inevitable fact in human life, so it cannot be delayed and avoided in any way. Health care that makes patients become a type of object in the hands of the technology, prolonging their agony with no possibility of healing cannot be imposed. (Representative of the Argentine Catholic Lawyers Association, committees plenary meeting, Honorable Senate of the Argentine Nation, September 27, 2011). [Own translation]

Letting a patient die "in peace and with God" was the representation that enabled the possibility of passing this law, since that meant that nobody could intervene in a "natural" process with artificial techniques. In the name of the autonomy of will, there is no possibility for individuals to decide on their own death, when and how to die the moment patients are notified about a terminal disease. Euthanasia and assisted suicide as figures that ensure the free disposition of the dying body were disqualified from the debate and for the approval of the law. This is consistent with the doctrine of the Catholic Church and that is why the law of "death with dignity" has not generated much ecclesial resistance and mobilization against it.

FINAL REFLECTIONS

We have analyzed the public intervention from the personalist bioethics point of view in relation to the debate on death with dignity in committees of the Senate of the Argentine Nation. In this work, we use the concept of expertise to characterize the legitimation process of political decisions by mean of convening the scientific and bioethical authorities, as a susceptible instance to resolve any conflicts of interests.[1,8] Using

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this expertise, trained bioethicists agents are called as scientific experts by various parliamentary committees. This is one of the points of view of public intervention. We were interested in analyzing this dynamic in the scene of a plenary meeting of parliamentary committees, in which the bills on death with dignity were discussed, because that is where the Catholic bioethicists interact with their theoretical opponents. We have focused on personalist bioethics experts who are placed in the intersection between religion and health, although the resource of bioethics expertise (secular or religious, not only Catholic) at parliamentary fields as a way to legitimize rules is consolidated as a tendency in several countries.[64]

Bioethics, in the context of Catholicism, appears as a scientific discipline that is studied and trained in detail and that helps to perform various public interventions in terms of the beginning, reproduction and the end of life, both in parliamentary or educational areas and in public hospital committees.[65]

This article can also be read in general as a contribution to the understanding of the contemporary processes of the government[5] and the administration of populations[66] using what Daniel Borrillo[8] has named "the bioethical mechanism," in which Catholicism plays a main role. The combination of these two perspectives provides an approach to distance the analyses that only refers to the instrumental-utilitarian component of public actions of Catholicism,[67,68] but it does not refuse such analysis. According to Joseph Gusfield,[4] it also emphasizes the existence of a symbolic element so that these actions can be understood as intrinsic in their own performance, analyzing them from a ceremonial and ritualistic point of view in different contexts, encounters and scenes[6] where expertise and public interventions are displayed from the bioethical point of view. The works on the public presence of Catholicism in Argentina are relevant to understand these processes. These works denote the existence of dynamic relationships of complementarity, competence and juxtaposition between Catholicism, the State and politics.[69,70] These investigations have shown the religious-political solidarities in legislative areas,[7] and the historical presence of a "movement of Catholic integrism" in Argentina, which has always been seen as a Catholicism which is "intransigent in its positions, unifying social, cultural and religious aspects, rejecting the private area, and which considers itself as a political body in the broad sense."[70]

Finally, this article is proposed as a contribution to the studies that analyze the intersection between bioethics, religion and beliefs from a sociological perspective, since there are few studies that analyze this interrelation, and only few works mention the role of the Catholicisms in this area.[8,65,71-76] In this sense, social sciences have made significant contributions to understand the process of consolidation of bioethics and have pointed out how this discipline promotes a "depoliticization" of moral conflicts[73] and the protection of a heteronormative and patriarchal model of society[77] using a diagram of legitimation based on the *expertise*.[8] The topics that bioethics addresses are articulated and comprehended by the religious agents, who find in that way political potential, which appears as "neutral and scientific." This phenomenon of the presence of a personalist bioethics (Catholic) can be framed within the process of constitution of Catholicism as a modern and public religion.[13,14,78,79] Personalist bioethics is not the only theological perspective of bioethics inside Catholicism, and Catholicism is not the only faith that has developed a bioethics perspective[79] either. The fact that legislators only convene catholic leaders of the personalistic perspective when requiring bioethics expertise calls is noteworthy. In the case of the law on death with dignity in Argentina, which has achieved broad consensus in society, only the opinion of some personalist Catholics was considered, without evaluating other Catholicisms and/or Christian and non-Christian religious agents. As mentioned above, other religious groups have participated in parliamentary debates as bioethics experts.[80] There are also bioethical perspectives developed in the framework of non-Christian faiths.[81,82] In the case of the debate

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on death with dignity, national senators privileged a debate in which prevailed the ideology of certain sectors of Catholicism and their points of view about death. Not all proposals within the framework of Catholicism were incorporated into the text of the passed law. Therefore, we can say that there is some autonomy between religious and political matters. However, we wanted to focus on the fact that only Catholic experts with a particular theological perspective (the personalist bioethics) were invited to the debate, putting aside other Catholic traditions and faiths.

FINAL NOTES

a. We use the concept of religious agent in reference to the notion of the social agent of the sociological theory.

b. According to Grau Vecina,[15 p.108] beginning in 1970s, a persistent vegetative state is known as "a clinical diagnosis that must be differentiated from other disturbances of consciousness (coma, brain death, locked-in syndrome, akinetic mutism, terminal phases of dementia). These patients maintain the constants and the vital functions, the sleep-wake rhythm and they lack voluntary activity. Vegetative state is defined as persistent when a patient remains in this state for a period of more than one month. It qualifies as permanent vegetative state when physicians established a prognostic criterion of irreversibility of such state." [Own translation] According to Gherardi[16 p.279] brain death means "Indemnity of the reticular activating system of the brain stem and of the respiratory and circulatory functions." [Own translation].

c. The public television channel – Canal 7 – titled a press report as "Family asks for death with dignity for Camila." [Own translation] The report described the family's request to terminate the "therapeutic obstinacy on their baby of 2 years as an act of love." [Own translation] The girl was born dead; physicians revived her and connected her to a ventilator. From that moment onwards the girl was connected to the ventilator in a permanent vegetative state, she did not respond to sensory stimulus, she did not develop hearing, vision and speech.[18].

d. Simon Lorda[46 p.75-79] argues that medical ethics in the Latin American area of the early twentieth century was nothing more than "Catholic moral theology in disguise." [Own translation] A manual widely available in medical schools was drafted by Luis Alonso Muñoyerro, "The Code of Medical Ethics," which had four editions (1934, 1942, 1950 and 1956). The author of this manual was Archbishop and martial general vicar. Simon Lorda(46) indicates that after the Second Vatican Council, moral theology was renewed as well as its influence on the codes of medical ethics that began to absorb the works of Diego Gracia, Javier Gafo, Francesc Abel, Marciano Vidal, Juan Masiá, Francisco Javier Elizari, Eduardo López Azpitarte, José Román Flecha.

e. The experts who attended as guest of the senator were: Florencia Luna, director of the area of Bio-

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ethics of the Latin American Faculty of Social Sciences (FLACSO) [Facultad Latinoamericana de Ciencias Sociales]; Daniel Chaves, professor of bioethics at Universidad de Morón; Carlos Castrillón, secretary of Medical Education at the Faculty of Medicine, Universidad de Buenos Aires (UBA); Cecilia Andrade and Laura Escapa de Souse of the Argentine Psychoanalytic Association; Maria Elisa Barone, neurologist, master in Applied Ethics at UBA and member of the Bioethics Committee of the Unique Central National Institute Coordinator of Ablation and Implant (INCUCAI) [Instituto Nacional Central Único Coordinador de Ablación e Implante]; Fernanda Ledesma, physician certified in bioethics by FLACSO and master in bioethics at Universidad Nacional de Cuyo, head of written assignments of the lecture of Bioethics II at the Faculty of Medicine, UBA, and coordinator of the Bioethics Committee of the Garrahan Hospital; Alberto Diaz Legaspe, consultant physician of the Latin American Organization of Social Security and former civil servant at different provincial ministries of Health; Maria Siruzzi, lawyer of the Health Observatory of the Faculty of Law, UBA; Vilma Tripodoro, physician, president of the Argentine Association of Palliative Health Care Medicine and professor of the Lanari Institute of UBA; Dario Jarque, judge of the city of Bahia Blanca; Juan Carlos Tealdi, physician, coordinator of the Bioethics area of the Human Rights Secretary's office of the Argentine Nation; Eduardo Sambrizi, from the Argentine Catholic Lawyers Association; Andrés Tello Cornejo, priest, executive secretary of the Ministry of Health of the Conference of Catholic Bishops of Argentina, priest and coordinator of the bioethics committee of a public hospital; Ruben Revello, priest, director of the Institute of Bioethics at Universidad Católica Argentina; Nicolás Laferriere, doctor of law, executive secretary of the Ministry of Culture of the Conference of Catholic Bishops of Argentina and director of the Centre of Bioethics called "Persona y Familia"; Ricardo Rabinovich, doctor of law, professor at UBA and at the Universidad del Salvador, bioethicist and former tutor of cryopreserved embryos of the City of Buenos Aires; Carlos Caramutti, president of the Argentine Association of Professors of Criminal Law, member of the Criminal court of the province of Tucuman, professor of Criminal Law at Universidad Nacional de Tucumán, and finally the lawyer Carlos Mosso.

f. This priest, a member of the highest local hierarchies, was a student of the other bioethicists who participated in the debate on the master's course of the Universidad Católica. This information, emerged from the fieldwork, illustrates the anchored relationship that these agents have between them and therefore we can assume that the deliberative strategy was planned. In addition, that same day, September 27, 2011, early in the morning, two of the experts who participated in the debate were exhibitors at the Days of Bioethics at the Sanatorium Mater Dei and publicly commented that they were "going together" [own translation] to the National Senate to give their opinion about the bills. This also makes us assume that the presentation may have been coordinated and planned beforehand.

g. The details on the omission of the curriculum of this expert was evident when the president of the commission, at the end of the debate, apologizes for not having introduced her, "because he did not have her curriculum among his papers" [own translation] and he invited her to make a brief presentation after her intervention. Those papers that the president of the committees referred to were the material that usually the administrative staff prepares for those who coordinate the debates so they can introduce the guests. During the fieldwork we have seen that the administrative head of the health commission had a friendly relationship with the priest of the Catholic Bishops Conference who participated in the debate and who was considered as "a very committed Catholic man." We cannot affirm that they did not prepare the curriculum of the expert of FLACSO to be presented by the president of the commission but it is suspicious that only hers was not there to be read to the audience. The omission of the academic credentials of this expert, before the audience, did not put her on an equal footing – as speaker – with the rest of the experts.

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