the HUMAN LIFE REVIEW

SPRING 1995

Featured in this issue:

Published by:

The Human Life Foundation, Inc.

New York, N.Y.

Vol. XXI, No. 2 $5.00 a copy

ABOUT THIS ISSUE...

...we welcome Spring with this *Review*, and look to the season's promise of renewal and new life, not least for the pro-life movement. May the winter of violence be replaced by a spring of renewed commitment to peaceful protest.

Spring finds some changes in our staff. I am now Executive Editor, a position I work at both at the office and at home while enjoying the new life of James Anthony, who at 6 months is our youngest and most entertaining staff member. Colleen Boland is now our Managing Editor, and as regular readers know, a promising new contributor.

Contributing Editor William Murchison, who leads off this issue with his sharp analysis of *l'affaire* Foster, is enjoying success with his new book, *Reclaiming Morality in America* (available from Thomas Nelson Publishers, Nelson Place at Elm Hill Pike, Nashville, Tennessee 37214; $16.99), which has been picked up by the Conservative Book Club.

We are pleased to have received many letters thanking us for publishing "The Lovely Girls: They Don't Come Any Betta," a short story included in Faith Abbott's new book *Acts of Faith*, which describes her journey into the Catholic Church. Copies of *Acts* are available from the Ignatius Press distribution office, 33 Oakland Avenue, Harrison, New York 10528 (at $14.95).

Anthony Fisher's article ("What Abortion Is Doing to Britain") is reprinted from *Priest & People*, a British monthly magazine published by The Tablet Publishing Company, which also publishes *The Tablet*, the well-known Catholic weekly.

Finally, Alasdair Palmer's excellent article, "Rigging the Human Market," is reprinted from another British publication, *The Spectator*, to which we are also indebted for our cartoons.

We hope you will enjoy the issue.

MARIA MCFADDEN
EXECUTIVE EDITOR

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Published by THE HUMAN LIFE FOUNDATION, INC. Editorial Office, Room 840, 150 E. 35th St., New York, N.Y. 10016. The editors will consider all manuscripts submitted, but assume no responsibility for unsolicited material. Editorial and subscription inquiries, and requests for reprint permission, should be sent directly to the editorial office. Subscription price: $20 per year; Canada and foreign $25 (U.S. currency).

INTRODUCTION

WE BEGIN THIS ISSUE in unaccustomed style. First, our lead article is "news" —it covers the controversy over the nomination of Dr. Henry Foster to be the next U.S. Surgeon General which, as we write, is still pending—rarely does a quarterly have the chance to be *ahead* of a story. Second, while we never fail to get lively prose from William Murchison, we'd say he has outdone himself on this one; it has an *élan* that pulls you into the still-unfolding action, much like a good detective story.

But that's fitting; there *is* a mystery involved, which Murchison sums up nicely:

> Even a Dr. Henry Foster, who was performing abortions way back when, now says he "abhors" the practice. However much or little he genuinely abhors it, the interesting point is the Clinton administration's licensing him to make such a claim. If the Clintonites thought the United States truly pro-choice, they would have had Foster declare, "Nine months before delivery, five minutes before delivery—what's the difference? I'll defend any woman's right to call off a pregnancy." Or something to that effect. The administration's own unease about abortion is highly visible in this controversy.

It is indeed amazing that, more than 22 years after *Roe v. Wade*, the Supreme Court's "final solution" to the abortion issue seems to be less and *less* final, despite near-total and certainly impassioned support from the Media Establishment. It's not just that the issue has not "gone away" as its devotees expected; rather, the sense of "unease" Murchison describes seems to be spreading more widely and deeply. Which vindicates former President Ronald Reagan, who had the foresight to title the historic essay he wrote for this journal (first published in our Spring, 1983, issue) "Abortion and the Conscience of the Nation"—Mr. Reagan's point was, Americans ought to have a very bad conscience over the slaughter of innocents unleashed by the High Court. Mr. Murchison's point is, they *do*, a truth illuminated by the visceral opposition to rewarding Dr. Foster's "perfectly-legal" sins with a position of honor.

Murchison makes another telling point: "Small people," he writes, "caught up in large controversies become large symbols." Dr. Foster fits the rule: he

has used his modest endowments to do rather well for himself by doing whatever has been "acceptable"—the morality of it all never seems to have crossed his career path—small wonder that he seems genuinely baffled by the uproar over the annointing of an abortionist as the "Family Doctor" of the nation.

As it happens, similar jolting surprises have befallen the global abortion *apparat* which, it also happens, is led by the same man who chose Dr. Foster, President Bill Clinton. It was clear, during the long build-up for the Conference on Population and Development held in Cairo last September, that the Clinton Administration meant to use the UN-sponsored forum to promote the particular brand of "reproductive health" that would mandate free-and-easy abortion worldwide. It looked like a cinch: the Clintonites were both able to manipulate a docile UN *and* willing to provide funding for compliance—what "underdeveloped" nation could resist such carrot-and-stick pressures? In the event, it was the world's premier *non*-nation that foiled the *apparat*'s agenda: "the Vatican" (read Pope John Paul II) somehow mobilized an *ad hoc* coalition that spanned Christian-Muslim conflicts and recruited "have-not" countries that seemed to have the most to lose from standing against the UN's "New Imperialism"—in any other context, the media might well call it a "miraculous" performance?

In effect, the Cairo conference amended the "reproductive health" doctrine to *exclude* abortion, meaning that the *apparat* limped into the second-stage conference, held in Copenhagen in March, in bad-tempered frustration: at stake was the agenda for a *third*-stage extravaganza set for Beijing in September. Mr. Michael Schwartz, who enjoyed a Danish treat watching it all, explains it this way:

> The way it was supposed to work was, the three conferences would build on one another to export Western-style feminism and social revolution to the backward parts of the world, along with Chinese-style population control to make sure progress is not held up by an increase in the number of the poor.

But it hasn't worked that way at all; the papal-inspired resistance movement gained new strength in Copenhagen, projecting our own abortion-fueled "Culture War" onto the world stage. It's quite possible, says Mr. Schwartz, that the "de-populators" may soon "find themselves in headlong retreat, as a moral reawakening grows out of this strange and providential Christian-Islamic alliance"—it's a fascinating story, which Schwartz reports with gusto—we hope we'll have more reportage from him in due course.

Mr. Wesley Smith also tells a good story, but not a happy one. Last November 8, Oregon made history by voting for "legalized doctor-induced death," as Smith rightly puts it. True, it won by a bare 51 percent majority, but it was nonetheless a stunning victory for the pro-euthanasia movement, which actually began in Germany a century ago. Of course it was set back

by the Nazi death camps—as Malcolm Muggeridge used to say, "Hitler gave euthanasia a bad name"—but Nuremberg has been forgotten, and the "Right to Die" is fashionable again. The question is: Are Americans ready to accept a "death-on-demand ethic"? If so, Smith fears it will have world-wide consequences, for "if we can export the morality and values of pop culture, we can certainly export the ethics of Jack Kevorkian."

Next we have a newcomer to these pages: Mr. David Quinn of Dublin was recommended to us by our London editor, Mary Kenny, as an "energetic young man, very bright"—just a few days later, we read (in the *Irish Times*) about the latest abortion controversy over there—the obvious thing to do was ring up Mr. Quinn, to see if he would report on the *brouhaha* for us. You have the result here: it's another good story, well told (it turns out that Quinn is a regular columnist for a Dublin paper, so it's no surprise)—his conclusion is that "the land of Saints and Scholars" is now also caught up in the global Culture War, which is sad news. We trust Mr. Quinn will also provide us with further installments.

What follows is a brief "personal reflection" by a Montana obstetrician, Dr. George Mulcaire-Jones, who has not only faced the "abortion dilemma" but also thought hard about it. It is far better read than described, so we'll simply recommend it, for your own reflection.

This time, our Maria McFadden also writes about things personal, and includes some personal reflections by her elder brother Robert, written not long before he died. Again, you can make of them what you will (they were not meant for publication), but the whole piece is hardly inappropriate for this journal, given that the subject is our primary concern, abortion.

Of course Robert's particular concern was the horrific fact that "pro-life" zeal had led to the murder of abortionists. That wasn't the "slippery slope" result anti-abortionists had in mind when they predicted—rightly—that legalized abortion would spawn progeny that would amaze even its ardent proponents. We seem to be approaching that point: "choice" severed from moral constraints ineluctably opens up previously-unthinkable possibilities, not least "business" ones. As Mr. Alasdair Palmer discovered, there is now a thriving trade in human "spare parts"—his investigation was inspired by an Indian gentleman who wanted to advertize (in the London *Spectator*) his willingness to "sell my fresh kidney at $150,000"—if the magazine ran his ad, it would get a fifteen-percent commission. We doubt that we need urge you to read this one?

We do hope you will read our final article, which also first appeared in a British magazine. The author is a Dominican priest (he is also a lawyer and bioethicist) who writes unabashedly from his Roman Catholic viewpoint, but we would argue that he has produced the kind of thing we *don't* get here: an *over*view, from the heights that Western civilization once aspired to reach.

His conclusion is sobering: we've fallen far down from "that ancient folk metaphor for security, 'safe as a child in its mother's womb.'"

* * * * *

Our appendices in this issue match our articles in both number and variety—and interest too, as we think you'll agree. Usually, we try to put them in some seemingly-logical order—this piece obviously ought to follow that one, etc. But this lot didn't fall into place easily: while most are related to what has come before, each stands on its own as well. So we decided to begin with another example of what we rarely see in the media: a non-emotional look at "the Abortion Business," which first appeared, appropriately, in the *Marketplace* section of the *Wall Street Journal*—presumably *Journal* readers would be interested to know whether or not abortion is a growth industry, etc. Well, it currently grosses (perfect word, that) almost half a *billion* yearly, but there are worrisome trends, investors beware.

Next Columnist John Leo (*Appendix B*) writes on our own lead, the nomination of Dr. Foster—Mr. Leo agrees with Bill Murchison that "a great many Americans really don't think an abortion practitioner ought to be surgeon general"—but he also points out a number of facts that illuminate the growing problems in the abortion industry (which you just read about in *Appendix A*). Then William Cheshire, another columnist, writes (*Appendix C*) about a message he got from "An offended reader" who objected to the use of "pro-abortion" to describe those who merely defend a constitutional right. Mr. Cheshire explains his reasons why he believes the objector "is stuck with the pro-abortion label, like it or not" (we think you'll like this one).

In *Appendix D*, the bioethicist Art Caplan echoes Wesley Smith's shock at what Oregon voters have wrought, but from another angle: Caplan says the law itself is so badly drafted that it opens up "a Pandora's box" of abuses that the voters "may long regret"—if they *live* long enough, that is. In *Appendix E*, George Weigel, who heads a Washington public-policy center, provides similar dire predictions about the likely abuses of "human embryo research" should current recommendations be acted upon—they could "hatch" Brave New World horrors even Aldous Huxley never imagined—Weigel too invokes Nuremberg, which promulgated a code which very specifically condemned the kind of "experimentation" now proposed.

In *Appendix F*, the focus shifts abruptly back to abortion, and the politics thereof. Mr. Benjamin Stein, a law teacher (but best known for his Hollywood movie roles), wants to know why many Republicans are "backpedaling" from support for "the right-to-life issue"—after all, Republican candidates have won impressive victories, not least last November 8, under the anti-abortion banner, which brought them "an astoundingly high percentage" of

the pro-life vote. Mr. Stein says it is "frighteningly cynical" to simply "Get the votes and run" from their pledged word.

Mr. Richard Brookhiser (*Appendix G*) examines the same vexed question, but from the other end of the telescope, so to speak. In his judgment, the anti-abortion commitment is smart politics—moral issues define a party. His question is: "Will the epitaph of the Gingrich Era be that the G.O.P. got term limits, while a million and a half human beings a year continued to get life limits?" We'd say that Messrs. Stein and Brookhiser put tough questions as starkly as we've ever seen them put; we trust that they will remind "moderate" Republicans that they have a lot to worry about.

But we don't want to leave only the politicians worried: there ought to be something we can all fret over? Alas, we fear we've found just the thing: in our final offering (*Appendix H*), Mr. Robert Wright, an editor of the liberal *New Republic* (by the way, Mr. Brookhiser is an editor of the "opposite number" *National Review*), delves gingerly into another Brave New World scenario that could become reality all too soon. It amounts to a new form of "eugenics"—with what we already know about our genes, not to mention coming discoveries, will we not "tempt more and more people to clean up their little corner of the gene pool"?

The possibilities are truly frightening, Wright says, especially because only the government can *stop* what's happening, and the "political difficulty" involved makes that unlikely, e.g., How do you say "No" to a mother who wants to prevent breast cancer in her daughters?

Put that way, it *is* frightening: "modern" governments aren't very good at saying No to anything—individual "rights" have all but destroyed the concept of *duty*, public or private. But there remain voices of sanity: as this is being written, the latest papal encyclical (*Evangelium Vitae*) is much in the news; we note that the Pope has something to say about the latest "prenatal diagnostic techniques," to wit:

> . . . it not infrequently happens that these techniques are used with a eugenic intention which accepts selective abortion in order to prevent the birth of children affected by various types of anomalies. Such an attitude is shameful and utterly reprehensible . . .

There you have it: all we need do is regain our lost sense of what is shameful and reprehensible—a most politically-incorrect idea but, in truth, precisely what this journal exists to advocate. We hope the present contribution to such "quixotic realism" makes good *reading* at the least, and we expect to have another round of it for you in due course.

J. P. MCFADDEN
EDITOR

Fostering Morality

William Murchison

In theory, the White House was abundantly entitled to ask: Why *not* Dr. Henry Foster as surgeon general of the United States?

Like his predecessor, the irrepressible (to put it kindly) Joycelyn Elders, Foster is black. That technically-irrelevant datum matters to an administration obsessed with "looking like America."

Having dumped Elders after the electoral catastrophe of last November 8, the Clintonites could, theoretically, mollify black Democrats by replacing her with Foster. Republicans, ever alert to the Democratic propensity for crying, "Racism, racism!" could be counted on at least to use him with civility. For Elders sympathizers, there was Foster's claim of "good" friendship with the fallen apostle of "solitary sex."

There was an additional advantage to the nomination: a certain gray-haired gravity to Foster's persona, in contrast with Elders' buoyant pop-offableness. Foster as a surgeon general seemed unlikely to throw conservatives into a swivet with some contemptuous, offhand remark about sexuality or the character of priests and bishops.

Foster, in fact, with his "I Have a Future" initiative at Meharry Medical College in Nashville, has expressly promoted to teenagers the value of sexual abstinence. For which the Bush administration, in 1991, named him one of its "Thousand Points of Light." This fitted in well with the Clinton administration's new public emphasis on moral matters.

The abortion question threw all these calibrated calculations into a spin. The momentum that propels any nomination was, in Foster's case, quickly expended. The nomination, after a few furious weeks of controversy, came to rest in winter mud. Confirmation hearings, as of this writing, were to begin in the early spring. Yet there is an atmostphere of death about the whole process.

This figures. Death is at the center of the Foster controversy—in a way that seems illogical to the Washington establishment. The Clinton administration's candidate to be surgeon general of the United States has practiced the indelicate science of abortion. With his own hands he has extinguished life in the womb.

This much he himself acknowledges—with vast reluctance, even as to

William Murchison, a nationally-syndicated columnist based at the Dallas *Morning News*, is the author of *Reclaiming Morality in America* (Thomas Nelson Publishers).

pinpointing the actual number of abortions he has performed.

The Foster controversy, even unconcluded, has moved beyond its original context. It is about Foster, yes: but, in a larger sense, it is about the 1990s, and about moral sloth—and commitment—as well as about the ongoing tussle between the two.

Surgeon-general confirmations are not exciting events—at least they didn't use to be, in the pre-Clinton era. Here's one confirmation process that, as Walter Cronkite used to say 40 years ago on the *You Are There* show, "alters and illuminates our times." For instance, we learn from the Foster controversy that the attitude of the Clinton White House toward abortion is somewhere between relaxed and indifferent. (Apparently this is notwithstanding the First Lady's recent affirmation, to *Newsweek*, that abortion is "wrong.")

Consider the administration's bewilderment when the question of Foster's prior participation in abortion arose. The administration seemed not to have thought about the question. Clinton, in nominating Foster, declared that he wanted his prospective surgeon general to lead a national campaign against teenage pregnancy. The White House staff seemed not to have taken into account that there are two ways of rendering teenagers un-pregnant—keeping them chaste (or at least "protected") or aborting the pregnancy.

Nor had the staff reckoned with the fact that Foster's branch of the medical profession—he is an obstetrician/gynecologist—is the branch that performs abortions. Had the staff not expected to be asked whether Foster had performed abortions, and if so, how many? The resultant confusion in the matter—Foster's as well as the staff's—enlivened news reports for days.

The number of Foster-performed abortions, when the matter at last was scrutinized, multiplied like the loaves and the fishes. Senator Nancy Kassebaum, whose committee has jurisdiction over the nomination, learned from Donna Shalala, Secretary of Health and Human Services, that Dr. Foster, in 38 years as an ob/gyn, had performed just one abortion. That assertion no more than commenced the conversation. Anti-abortion groups pursued the matter, e.g., Foster's name rang the memory of one veteran "pro-life" activist, Mrs. Randy Engel, who checked old files, and hit paydirt—a transcript of a 1978 federal hearing quotes Foster as saying "I have done a lot of amniocentesis and therapeutic abortions, probably near 700."

The nominee himself, as the temperature in the fish bowl soared, acknowledged a hand in "fewer than a dozen pregnancy terminations," un-

dertaken "primarily," as he said, to "save the lives of women" or to assist a rape or incest victim. Then his memory improved. The tally, he told Ted Koppel on *Nightline*, was actually 39. However, it turned out that that wasn't counting experiments he had supervised in the early '80s, during which 55 abortions had been performed. Still officially unclear is whether Foster, prior to 1978, had a hand in "near 700" therapeutic and amniocentesis abortions. The transcript of a meeting of the Ethics Advisory Board of the Health, Education, and Welfare Department shows him making such a claim. Foster denies he made the statement. The contradiction had not, at the time of this writing, been resolved. Nor was there hard evidence to confirm or dismiss, either one, reports that he knew about, and failed to object to, a federal medical experiment that involved withholding treatment from syphilitic black men.

The point remains as before: abortion wasn't even on the White House radar screen at the time of Foster's nomination. One divines, not exactly for the first time, the measure of White House sensitivity on this most sensitive of public questions. The measure clearly isn't large.

Likewise the controversy underlined the nominee's own comparative indifference regarding unborn life and its integrity. On *Nightline* Foster claimed to "abhor" abortion, which he said means "failure." It means a great deal more of course—like the violent cessation of a beating heart. But more interesting than the matter of word choice is the question: the nominee for the job of America's No. 1 medical spokesman has performed abortions he "abhors"? Why? If abortion is as abhorrent as Foster says, isn't one's moral duty to battle and conquer it?

Take the matter farther: How does a doctor, his conscience fighting down abhorrence and disgust each time he operates, forget how many such operations he has done? You would suppose each was seared on his memory. Appendectomies, or even angioplasties, might swim together in a veteran doctor's recollection. But to lack undifferentiated memory of a procedure you abhor? It calls into question the assertion of abhorrence. The only warranted conclusion is that abortion is, to Foster, more a personal disappointment than a moral catastrophe, hardly an agreeable experience, but nothing to take home from the office—nothing likely to stare back, uninvited, from the depths of a double Scotch.

Foster's assertion—"I don't know of a single legislator in Washington whom you could walk up to and ask, How many times have you voted on a labor bill? and get a specific answer"—is unimpressive in the extreme. A labor bill, a human life—Where's the equivalence? That Dr. Foster

suggests an equivalence suggests something equivocal about Dr. Foster.

But that very act of equivocation is, paradoxically, a light in the cultural darkness, showing us what really is behind the struggle over the surgeon generalship. Our minds are concentrated wonderfully, as indeed they need to be.

Consider what the surgeon general has become—namely, our country's "family doctor." Not just a bureaucrat in a Gilbert and Sullivan uniform, but rather a kind of moral presence, licensed (rightly or wrongly is another matter) to prescribe for our collective good. Dr. Luther Terry, in the 1960s, launched, on purely medical grounds, what has become in our own time an ideological war against cigarettes. Dr. C. Everett Koop, appointed by Ronald Reagan, preached compassion for AIDS victims. The S.G., to carry on this mission, needs stature—the very quality Joycelyn Elders so conspicuously lacked.

With Foster, the stature question arises in a fresh and startling way. The surgeon-general designate is a sometime abortionist. A cardiologist, a podiatrist, a neurosurgeon, an internist—any one of these would be a fine surgeon general. Even a regular—i.e., non-aborting—ob/gyn would be fine. Foster is less than fine. The sticking point is his embrace of something the U.S. Supreme Court calls a profound constitutional right.

Wait, what is this? You can't honor the Constitution in its fullness and still be surgeon general? Actually, you can't—at least not when the Constitution is distorted by a Supreme Court decree at odds with common moral understanding. The court may say with all solemnity that human life in the womb is not due the protections of human life outside it. Whenever it says so, the court must prepare itself not to be believed. A great cross-section of Americans knows better.

This is equivalent to a crisis of the regime. Here we have a surgeon-general designate who, in the matter of unborn life, backs the court's interpretation of the Constitution. Public officials do not normally get in trouble for submitting to the Constitution as judicially construed. Are not the court's interpretations authoritative? Are not public officials—acolytes of the Constitution—bound to go along? To stretch the conversation even farther, can't a doctor do what the court says he may do—*viz.*, perform abortions—and escape reproach? Dr. Henry Foster, when he introduced instruments of death into all those wombs—one, or 12, or 39, or 700—had official permission. The court said, with only two holdout votes, that the wombs' owners had a constitutional right to invite him into these mysterious, even sacred places. He himself of course enjoyed the equivalent right of entry. In he went. Would we, the citizens, now hold such

decisions against him, when he was only following, ah, constitutional interpretation—merely doing as thousands of others were doing?

Dr. Henry Foster cannot now believe his eyes. A multitude of citizens hold against him exactly those silent, terrible entries into precincts where, faintly but decisively, human hearts could be heard beating and tiny human forms swam in amniotic fluid. Dr. Foster had no right there, these citizens would object. He had, in fact, every obligation to stay out, so that the hearts might come to beat louder and louder, and the life forms increase their resemblance to his own form, and finally, at the end, emerge squalling, kicking, sucking, cuddling.

Not that Dr. Henry Foster was the only physician, by any means, to perpetrate such entries! He merely happens to be the only one under consideration right now as the family doctor to the American people. He does, or did, what he professes to abhor. This is a strange position in which to view one's family doctor. It makes one wonder about his conscience, his ethics, his underlying principles.

A doctor heals, cures, gives life, or renews it. A death doctor, or a doctor-butcher, is a contradiction in terms, like a carpenter with a sledgehammer. Charles Coburn, in the 1941 movie *Kings Row*, amputates Ronald Reagan's legs so as to punish him for fancied offenses. The audience gasps at the foulness of betrayal. So, in more terrible degree, with the doctors of Nazi Germany—the ones anyway who participated in the unspeakable experiments of that era. These were not doctors, for all the fine Heidelberg diplomas that may have decorated their office walls. Their profession was death, their method violence. All were betrayers.

As Western civilization turns savagely against itself, it becomes harder to remember, and come to terms with, civilization's ethical legacy. Reading of doctors and abortion, one thirsts for some mention of the Hippocratic Oath. The oath arose in the pagan, not the Christian, world. Hippocrates, a member of the famous family of priest-physicians, the Asclepidae, lived almost four centuries before Jesus Christ. The medical profession's ethics he unforgettably encoded, and doctors for centuries have sworn allegiance to his compilation, not just as "a nice thing to do" but as a stimulus to recollection of the doctor's calling to the life of healing and service. Among the oath's memorable prohibitions: the administration of a pessary to produce an abortion. This prohibition, it might be remembered, dates from an era when the militaristic Spartans left unwanted babies to die of exposure on hillsides.

Not that the oath—which, to be sure, has no legal force, in and of

itself—restrained yesterday or today 100 percent of the swearers. There have always been abortionists, back alley or front office—but not holding the office of surgeon general of the United States; not family doctors to the American people. This gives the Foster nomination a wholly different coloration. For the Senate to confirm Foster, and give him the rank of chief medical exhorter, would be to come down on Foster's side, over and against that of Hippocrates—to declare the ethical question inoperative to abortion, when in fact the ethical question is paramount.

A thing like the Foster nomination is possible only in the context of America's ongoing moral muddle. On the question of unborn life, ethics and morality say one thing, the Supreme Court and the media another. Who decides? Why, the autonomous individual. Presumably this means not just pregnant women but doctors. The Supreme Court has liberated the likes of Henry Foster from the necessity of observing "outdated" norms.

The interesting datum is that autonomous individuals have for some years been working hard on this whole question of abortion on demand, and that increasingly they line up with Hippocrates. The Supreme Court cannot have anticipated this result. But polls indicate growing unease regarding the spacious permission the court extended in *Roe v. Wade*: which permission Dr. Henry Foster has gratefully exercised.

It is hard to get a fix on the public mood, because there is not just one mood, there are several. James Davison Hunter, in *Before the Shooting Begins: Searching for Democracy in America's Culture War*, points to Americans' "ambivalence" in the matter of abortion. For example, one baby-boomer architect from Annapolis, Maryland, is quoted as saying, "I just don't want to get into philosophical or theological wrangling. I know how I feel, and my feelings are valid."

Where "feelings" are "valid" as well as universal, we can expect a variety of viewpoints. Yet even the architect, who supported a woman's right to an abortion in the first trimester, was "very uncomfortable," Hunter reported, "with regard to late-term abortions."

Just this confusion feeds the sense of unease with easy abortion. In a previous article for this journal, I mentioned the Roper poll commissioned by Dr. James Dobson's Focus on the Family and Gary Bauer's Family Research Council. Rehearsal of the poll's results is relevant to the present inquiry.

The poll indicated rockbottom, 19 percent opposition to abortion in "any circumstances." Add another seven percent who would allow abortion to save the mother's life and, on top of that, 18 percent who would add the

exception of abortion in cases of rape and incest. You have by this time 44 percent who object to abortion for mere convenience.

Another 11 percent embrace the preceding exceptions and add a few more—abortions where there is "infant deformity, disease or retardations, and where the child is unwanted and will not have a good quality of life."

This is 55 percent of Americans with scruples, shall we say, about an operation such as Dr. Henry Foster has performed in apparently unquantifiable circumstances. Between those opposed to all abortions and those willing to polish off a child unlikely to have "a good life," there are clearly major differences. Still, there is common concern for life, and that is not trivial.

Is America's conscience evolving in a pro-life direction? The conclusion is risky but hardly extravagant. If abortion were so unmitigated a blessing as the Supreme Court implied in 1973, the nation ought by now to have experienced conversion. Instead of calumniating Justice Blackmun's reasoning in *Roe*, we should be burning incense to him as one of the great modern prophets. But opposition to abortion, far from abating, has intensified. Two decades of abortion on demand have been, if deadly to millions of babies, fruitful for moral examination. Even a Dr. Henry Foster, who was performing abortions way back when, now says he "abhors" the practice. However much or little he genuinely abhors it, the interesting point is the Clinton administration's licensing him to make such a claim. If the Clintonites thought the United States truly pro-choice, they would have had Foster declare, "Nine months before delivery, five minutes before delivery—what's the difference? I'll defend any woman's right to call off a pregnancy." Or something to that effect. The administration's own unease about abortion is highly visible in this controversy.

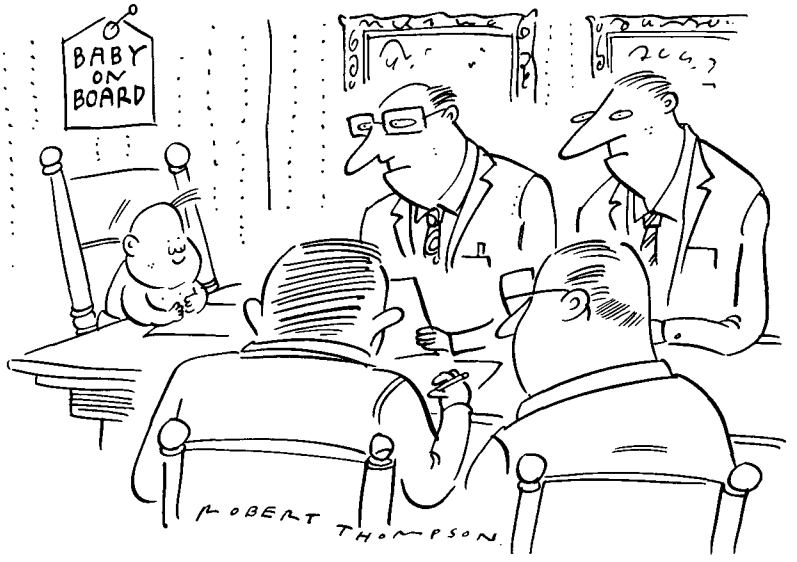
This is all the more reason for the Senate to defeat the nomination—with due resepct for Foster's commendable diligence in promoting sexual abstinence among teenagers. The nominee appears, come to think of it, an unlikely sacrificial goat. There seems in him nothing of the fanatical, ideology-serving Nazi doctor; nothing even Charles Coburnesque. By his own lights, and his family's, he is doubtless a decent man. But none of that is to the point.

Small people caught up in large controversies become large symbols. No controversy today is greater or more urgent than abortion, which goes to the meaning of human life and destiny. A dedicated pro-life campaigner is not going to become surgeon general while the Clintons remain under the White House roof, but neither should a doctor who has performed

abortions without at least making—*à la* Bernard Nathanson—the necessary public acts of contrition and remorse.

It might be useful, actually, to have as surgeon general a converted abortionist: someone who has looked directly into the moral abyss and is here to warn us how much more horrible matters will get unless we walk a different path. That would be a man, or woman, worth listening to. Poor Dr. Foster is not that man. He is, rather, a reluctant symbol of political calculation and moral confusion in high places as well as low.

If one feels sorry for a probably well-intentioned man who wandered into the political lion's den of accusation and exposure, one feels far sorrier for the true victims of modern moral technology. Not one of them have we ever seen—at least not as God intended they all should be seen. None has a name of his own. But the fates they met, and still meet, haunt our waking and sleeping. The Foster controversy proves that to perfection.



THE SPECTATOR 23 July 1994

The Culture War Goes Global

Michael Schwartz

Three major United Nations conferences within the space of a year are carrying the culture war onto the international stage and turning into major battlegrounds over the establishment of the New World Order. But what is much bigger news is that the good guys are winning.

The way it was supposed to work was, the three conferences would build on one another to export Western-style feminism and social revolution to the backward parts of the world, along with Chinese-style population control to make sure progress is not held up by an increase in the number of the poor.

The Third International Conference on Population and Development (ICPD) in Cairo would set the targets of birth-rate reduction and legalized abortion for the whole world. The World Summit on Social Development in Copenhagen would build the funding mechanism for carrying out the plan. And the Fourth International Conference on the Status of Women in Beijing would be the great triumph of world feminism that would overturn established customs and institutions and replace them with the social vision of Bella Abzug.

The Cairo conference in September, 1994, was expected to make up for the shortcomings of its two predecessors, the 1974 Bucharest conference and the 1984 Mexico City conference. According to President Clinton, the Cairo conference would guarantee to women throughout the world the human right to reproductive freedom, as well as initiate serious steps to address the world population crisis.

There is a latent contradiction between these two goals. As long as it is the case that mothers want fewer children, then assuring them "reproductive freedom"—in the form of voluntary access to contraception, sterilization and abortion—will contribute to reducing birth rates. But once fertility rates reach a level at which mothers are satisfied with the number of children they have, freedom has done what it can do. What "reproductive freedom" has done in North America and Europe is to depress birth rates to the point that post-Christian Western nations are on a course for biological extinction.

But in the developing countries, people have not caught on to the West-

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ern attitude that their own offspring should be regarded as unworthy of existence. They keep on having children on *purpose*—they seem to like them. And in that kind of society, "reproductive freedom" alone will not reduce the population. To reach the kind of objectives "population control" demographers talk about, something more than "reproductive freedom" is needed, something like China has. As Alan Guttmacher wrote long ago, "Each nation must be free to choose its own form of coercion."

World population conferences are not about planning your family. They are about population control. They are aimed at getting results, and those results can come about only by instituting some sort of enforceable means of compliance. The Bucharest conference in 1974 failed to achieve that goal because the small countries on whom compliance would be forced found an ally in the Soviet Union. Marxist orthodoxy rejects the Malthusian theory, and so the Soviets, then still a superpower, refused to go along with the lords of population control.

The 1984 Mexico City conference was even worse. Ronald Reagan was then President of the United States, and he sent a U.S. delegation led by former Senator James L. Buckley and packed with "pro-lifers." The Americans in Mexico City seemed more concerned about stopping abortion than with depopulating Africa. And without a strong push from the U.S., international population-control efforts are doomed to failure.

There would be none of these problems at Cairo. The United States was unchallenged as the world's only superpower, and the President of the United States was a "friend of family planning." A new rhetoric of "sustainable development" had been developed at a previous UN conference on the environment, and this would get a lot of play at Cairo as the rich nations made the case that the poor nations, too, could become rich if only they had fewer people. Few observers had any doubt that the Cairo conference was certain to achieve its objectives.

The Vatican could see what was coming in Cairo. In previous conferences the vulnerable nations of the world had a major power to defend them against the more brutal proposals for depopulation. Now the only superpower in the world was promising to take an aggressive anti-population line, and the rest of the developed countries seemed ready to go along with the U.S.

At least as early as the first half of 1993, the Holy See began efforts to organize some resistance to the population-control juggernaut. One important figure in that effort was Alfonso Cardinal Lopez Trujillo, head of the Pontifical Council on the Family, who spoke about the impending show-

down in Cairo to Catholic audiences around the world. It was Cardinal Lopez Trujillo's warnings that came to the attention of Argentine President Carlos Menem.

Menem is a Catholic, and president of a predominantly Catholic and Hispanic country. But he himself is of Arabic descent. Once he understood how important it was for the less-developed countries to defend their independence and their posterity against the population zealots of the North, he found himself uniquely well-suited to approach the Islamic countries and to seek an alliance. This was the beginning of a remarkable and historically-significant working relationship between the Muslim countries, most of Latin America, most of sub-Saharan Africa, and the Holy See in defense of the moral and cultural standards rooted in the Bible.

For 1,300 years, Islam and Christianity have been adversaries, and that tension has by no means ended. But both religious traditions share a common moral inheritance, and they both face a common foe in the aggressive secular culture of the West, especially as it is tied to a corruption of personal and public morals. Christians and Muslims agree that abortion is a grave evil. They agree that practice of chastity is necessary to sound family life. And they agree that families are the fundamental unit of society. On all three points, these "religions of the book" are in irreconcilable conflict with modern secularism.

The Vatican-Islamic alliance did not become visible to the media until the time of the conference itself. Both UN and U.S. government officials were brimming with confidence as the week-long conference began, and the world media were filled with upbeat stories about how the population crisis would finally be addressed. But each day the news from Cairo seemed to get worse. For the sidelines observer, the placement and length of coverage given the Cairo conference by the Washington *Post* was a perfect barometer of its fortunes. Starting with a front-page lead with photo, the news moved to page three, then to the second section, and finally disappeared altogether so that, according to the *Post*, the conference never really did end.

Each day the *Post* and its twin the New York *Times* would describe the Holy See as an isolated, obstructionist force, standing hopelessly against the tide of progress. According to the American newspapers of record, the Holy See had virtually no support for its positions. But by the end of the week, it was clear that "the Vatican" had managed to have its way on virtually every disputed point. Abortion was repudiated, and the objectionable language was either eliminated or qualified. Instead of a foreign policy

triumph, Cairo had turned into a stinging embarrassment for the Clinton Administration.

Alone among major American media, *Time* magazine recognized what had happened when it made Pope John Paul its "Man of the Year." More than any other single person, it was the Pope who turned Cairo around. He had achieved a victory no one had expected by forging an alliance of nearly all the poorer countries of Latin America, Africa and the great Islamic crescent from Morocco to Indonesia. No pope since the Reformation had had such a significant influence on temporal affairs.

The Cairo conference also gave some combat experience to a loosely-knit international group of pro-life and pro-family lobbyists who attended the conference as representatives of non-governmental organizations (NGOs). The NGOs have been a highly-visible part of these recent UN conferences. The most prominent of them are the International Planned Parenthood Federation and Bella Abzug's Women's Environmental and Development Organization (WEDO), although there are hundreds more, most of them based in the United States or Europe, and nearly all of them representing some left-oriented interest.

The UN leadership likes NGOs because they are highly motivated and ideologically driven to work for goals the UN approves of, but do not have the real-world responsibilities of governments. Governments always have other priorities, and often have other ideas, so they are simply not as reliable as NGOs in pushing forward the UN agenda. Hence, the representatives of NGOs have been given access to the conferences.

Mrs. Abzug is the most visible NGO personality, and her WEDO organization plays a significant role in shaping policy at the UN agencies. She shuffled off the U.S. political scene after losing a congressional re-election bid, but she has found a second career in using the UN to change the world. And IPPF, of course, has for long been a very important influence at the UN.

Surprisingly, however, most of the NGOs are remarkably ineffective at influencing the proceedings of the conferences. They issue manifestoes, distribute literature, and hold interminable press conferences. But they seem to talk only to themselves, and to those who already agree with them. Their presence at these conferences seems to be nothing but a self-indulgence, a vacation to an exotic place with some idealistic cause as the excuse.

The pro-life NGOs are a major exception to this pattern. Those people come to lobby the national delegations and affect the outcome of the conferences. They explain the meaning of unfamiliar terms to the delegates, draft language, itemize talking points, and get commitments from delegates

to raise certain issues in working sessions. At Cairo they learned how to do it, and at Copenhagen they perfected their skills.

Lest that sound patronizing, the task of explaining unfamiliar terms is of great importance. The conference documents are written in the language of Anglo-American social activists, and are chock-full of euphemisms, buzz words and circumlocution. The classic case is the term "reproductive health." As any American knows, this is a euphemism for abortion. But for a diplomat or government official from Zimbabwe or Peru, the term is simply incomprehensible.

First, there is the matter of translation. As George Weigel noted, this term is expressed in other languages by words that literally mean things like "health that goes on and on" or "health about the begetting of children." Even after that hurdle is cleared and there is some understanding of the literal meaning of the term, it is necessary to explain that "reproductive health" has been officially defined by the World Health Organization to include "fertility control," which in turn has been officially defined to include "termination of pregnancy." All of which is a convoluted but necessary way of saying that when the term "reproductive health" appears in a UN document, it means "abortion." How is the Labor Minister from Pakistan going to know that unless someone tells him?

In explaining such things, the pro-life NGO lobbyists made themselves genuinely useful to the delegates. In return, the delegates became motivated to speak out for what they and the people of their countries believed.

Six months after Cairo, the scene shifted to Copenhagen for the World Summit on Social Development. The subject here was money. Specifically, there were two very far-reaching proposals sought by UN leadership. One was a tax, to be collected directly by the UN, on international currency transactions and communications. This could have provided the UN with an estimated $1.5 trillion a year in revenues.

The other major proposal was something called the "20/20 Initiative." Under this scheme, each aid-receiving nation would agree to dedicate 20 percent of its total budget to spending for specified social-development purposes, while each aid-granting nation would devote at least 20 percent of its foreign aid to this same list of targeted objectives. In addition, each aid-granting country would agree to put at least 0.7 percent of its national budget each year into foreign aid.

These were revolutionary proposals. If adopted, they would have made the UN independent of the sovereign nations that comprise it, and would have subjected each country to UN dictation on its spending priorities.

Both proposals, as it turned out, were dead on arrival for precisely those reasons. The newspapers reporting on the Summit blazoned the failure of these plans as early as the second day of the conference. By the third day, the NGOs had issued a declaration of their own. By the fourth day, there were carefully-staged demonstrations in the convention center protesting the failure of the delegates to take seriously their obligation to fight poverty. And by the end of the week, when nearly 100 heads of state arrived for the solemnities, everyone was papering over the disaster by claiming the Summit had been a marvelous success.

Coming into the Copenhagen conference, the hot issues like abortion and religion that gripped media attention in Cairo were just not prominent. The UN leadership, hoping to get their financial ideas approved, would have been happy to keep them out of the discussion. But the Abzug/IPPF constellation of NGOs, as well as the U.S. government, were still smarting from what happened in Cairo and did not want to lose this opportunity to regain the initiative.

At the urging of the feminist NGOs, the U.S. had put "brackets" on such bland items as a paragraph in praise of family stability, and a sentence condemning "gratuitous sex and violence" in the entertainment media. Moving on to meatier issues, the Americans and their Canadian and European allies had peppered the document with suggested references to "reproductive health," "diversity of family forms" (read homosexual "unions"), and "gender equity."

Happily, the Americans and their allies lost on all of these controversies. Nonetheless, it is shocking to think that our country, in its international diplomacy, has become a positive force for evil.

If Americans have any doubts about the Clinton Administration's commitment to cultural revolution, attendance at the working-group sessions in Copenhagen would have erased them. The U.S. negotiators were tough in arguing—all in suitably euphemistic terms, of course—for the worldwide extension of abortion, gay rights, contraceptives for children, and the suppression of parental rights. Given the immense power of the United States and the fact that its demands were seconded by the European Union countries, Canada, and Australia, it is remarkable that tiny, debt-ridden countries like Benin were willing to speak out in defense of civilized moral standards. Yet it happened.

As in Cairo, the alliance of Muslims, Africans and Latins, with the Holy See delegation providing a great deal of behind-the-scenes strategic guidance, was successful in eliminating nearly all of the cultural radicalism in the document. Canada managed to add a section in support of school-

based health education programs, but "reproductive health" was specifically excluded, and strong parental-rights language was added. The term "reproductive health" does appear four times in the document, but each such reference is tied to a disclaimer which refers back to the Cairo exclusion of abortion from "reproductive health."

In short, Copenhagen became "Strike Two" for the forces of cultural radicalism.

The U.S. delegation included Health and Human Services Secretary Donna Shalala and Undersecretary of Education Madeleine Kunin, two of the more ardent feminists in top Administration posts. Hillary Clinton addressed the conference early in the week, promising $100 million in U.S. aid over the next ten years for women's education. Needless to say, she has no legal authority to make such commitments, but the NGOs and the conference media simply complained that the Americans were being cheapskates in promising so little.

On Wednesday, March 8, International Women's Day was celebrated, and Mrs. Abzug preened for the media. Ironically, on that same day the Chinese government made available some copies of its "Law for the Protection of the Rights and Interests of Women," adopted in 1992. With the Fourth International Conference on the Status of Women scheduled for Beijing only six months later, the Chinese government was suffering some public-relations problems over its own attitude toward women. Presumably, the reason why they distributed copies of the law was to show how enlightened they are.

One of the pro-life lobbyists picked up a copy and read Article 42: "When a wife terminates gestation *as required by the population programme* her husband may not file for divorce until six months after the operation . . . " There it was: official written acknowledgement that the Chinese population program includes forced abortion. The U.S. State Department and the UN Fund for Population Activities had been strenuously denying that China forces women to undergo abortions, despite the first-person testimony of dozens of vicitms of this policy. Now here was authoritative evidence, ironically in a subordinate clause in a law on women's rights.

Overnight, several pro-life women printed up flyers about their suffering sisters in China, and they appeared next morning at Bella Abzug's Women's Caucus meeting to talk about the issue. One of those pro-life women reported that a majority of the Women's Caucus attendees joined in crying out to protest against the China policy before one of Bella's enforcers moved to bring the situation back under control. It was this lady's

judgment, after attending several Women's Caucus meetings, that the international feminist network is extremely weak, with little ideological unity and no clear agenda. It was only the force of Abzug's personality that was holding it together, and Bella has no charismatic successor waiting in the wings.

If that analysis is correct, it could be good news for the Fourth International Conference on the Status of Women, to be held in Beijing in September, 1995. This is the last chance for Abzug to recover from the defeats at Cairo and Copenhagen, and it will probably be the last great event in her career. She will certainly have center stage and plenty of help from the Western media. But if Copenhagen showed anything about Bella Abzug, it is that she is much more effective as a media star than as a field tactician. Abzug had an army of supporters at Copenhagen (and at Cairo), but they were never used effectively. They got plenty of media coverage, but they had virtually no impact on the documents that were produced.

Abzug and her allies will have an ambitious agenda for Beijing. They not only want to use Beijing to get abortion/population-control items they failed to attain in Cairo, but also the empowerment-of-women issues that failed to make it into the Copenhagen document, plus some entirely new and very kooky ideas designed especially for Beijing, such as the protection of the rights of prostitutes and other commercial-sex workers such as strippers and porn models.

The preliminary draft document which the UN staff has prepared for Beijing is written from a more conventional feminist perspective. Its weaknesses are mainly those of omission (most notably, it lacks any real recognition of marriage and family life as being of value for women), but it does not contain the wild-eyed brand of feminism which Abzug and her allies are pushing.

With or without backing by the U.S., it seems inconceivable that the delegations from most of the developing countries will tolerate a document that endorses rights for lesbian mothers. The error of the cultural radicals coming into the Beijing conference is that they seem determined to alienate the majority of the world by overreaching themselves.

This provides a new opportunity for the pro-life NGOs. Cairo was a survival battle. Powerful, almost irresistible, forces were planning to impose abortion on the world, and turning that assault back was the definition of victory. The Copenhagen conference had a different dynamic. Here the cultural radicals were trying to insert their ideas into a fundamentally-neutral document. Again, a defensive strategy was called for, but it was defense from a position of strength rather than of weakness.

In Beijing, the dynamic will be different yet again. If the previous conferences are any guide to the expected attitude of the delegations from the developing countries, there is no realistic likelihood that Abzug and her troops will succeed in getting their ideas accepted. As they have met defeat, they have simply become more strident and unreasonable. By September, they are probably going to be little more than a sideshow, completely disconnected from the business of the conference.

This offers the pro-life network a unique opportunity to shape the discussion, and one issue clearly presents itself as the focus for driving a solid agenda at Beijing. That issue is prostitution.

Prostitution has, throughout human history, been the most egregious assault on the status of women. It is slavery. It turns a woman into a commodity, denying her humanity. And unlike intractable problems such as poverty and unemployment, prostitution can be ended by concerted human effort. Millions of girls and women are dragged into this slavery, and this happens because political leaders are in collusion with organized crime, and turn a blind eye to this most vicious form of human exploitation. The Beijing conference, if it is lobbied properly, could become the launching pad for a worldwide crusade to stamp out prostitution and other forms of commercialized sexual exploitation.

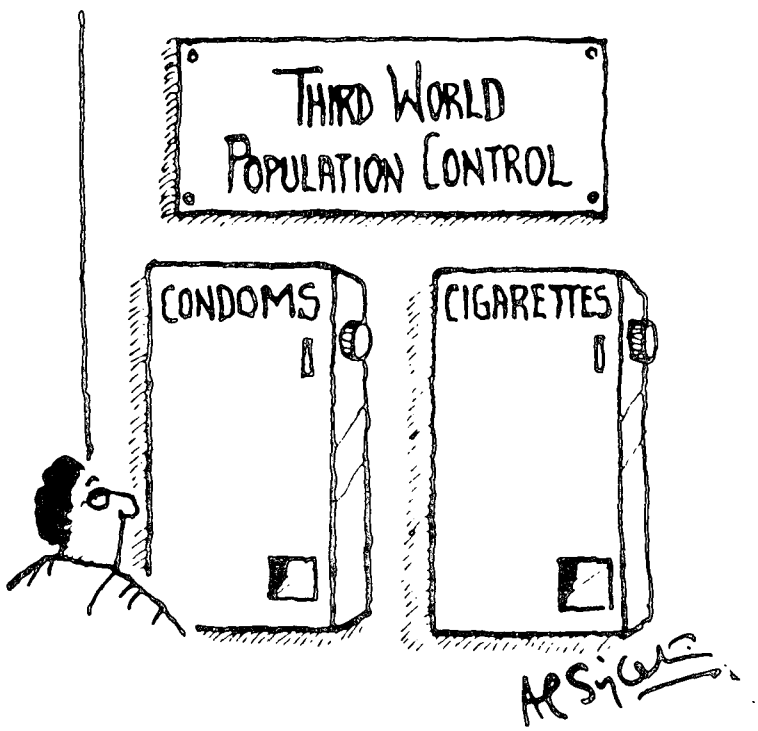
This is, after all, getting back to the roots of feminism. In the Victorian era, the "women's movement" had as its objective "social purity"—shutting down the brothels and saloons. The international feminist network will be split between those who doggedly cling to a nihilistic ideological position and those who actually care about the well-being and dignity of women. The dogmatists will be out with Mrs. Abzug, demanding the right to paid holidays for prostitutes. The pro-woman forces will be inside the conference hall, demanding an end to the enslavement of women.

And if the central question at Beijing becomes "How do we put an end to prostitution?" rather than "How do we free women from patriarchy?" then many key questions answer themselves. For one thing, strengthening the family as the basic unit of society and advocating marriage become positive ideas instead of heresies. Passing out condoms to schoolgirls will be condemned instead of promoted. In fact, the whole thrust of the conference could be reversed and become pro-family if the issue of prostitution can be raised to prominence.

If this were to happen, it would complete an astonishing and unpredicted victory for traditional moral standards worldwide. Last year, before Cairo, it appeared inevitable that the population control zealots would have their

way. Now they have been stopped. Six months from now, they may find themselves in headlong retreat, as a moral reawakening grows out of this strange and providential Islamic-Christian alliance in defense of the family.

In which case, *Time* will have little choice but to name John Paul II its Man of the Year for 1995 as well.



THE SPECTATOR 24 September 1994

Unnecessary Tragedy:

Assisted Suicide Comes to Oregon

Wesley J. Smith

Euthansia and assisted suicide have been prohibited throughout most of the world's history. To be sure, euthanasia has been practiced in a few aberrational societies—in ancient Greece, babies born with birth defects were sometimes left on hills to die, a practice adopted to evade the ethical proscription against direct killing. In more recent times, Germany euthanized as many as 300,000 victims (mostly disabled children or the elderly and mentally retarded), who were the first blood sacrifices to Nazi madness now known as the Holocaust.[1] Now of course there is the Netherlands, which—although it remains technically a crime—today permits euthanasia and assisted suicide as a matter of routine. (According to a 1991 Dutch government study known as the Remmelink Report, approximately nine percent of all Dutch deaths are doctor-induced.)[2]

Then along came Measure 16 in Oregon.[3] In what may prove to be a truly historic event, on November 8, 1994, fifty-one percent of Oregon voters gave their assent to a measure that formally legalized doctor-induced death. As this is being written, it is not yet known whether Measure 16 represents the high water mark of the pro-euthanasia movement destined to ebb into unimportance, or the vanguard wave of a devastating *tsunami* that will destroy all remaining vestiges of a sanctity-of-life ethic.

After being rejected for nearly three thousand years in law, medical ethics,[4] and morality—for reasons difficult to grasp—euthanasia has been an ever-present threat to the medical and legal ethics of the 20th Century. Usually, pro-euthanasia sentiments have expressed themselves as an under-current of advocacy by the medical and academic *intelligentsia*. But occasionally, euthanasia has been openly practiced—always with devastating consequences.

The roots of the drive to legalize euthanasia in the 20th Century can be found in the close of the 19th Century when German theorists were beginning to posit the right of the state to commit euthanasia in order to benefit the *Volk* (people). This theory was most notably advocated in an 1895

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book called *Das Recht auf den Tod* (*The Right to Death*), by Adolf Jost. But it was not until the 20th Century was well under way that these euthanasia seeds began to sprout. Robert J. Lifton, a psychiatrist, author and Holocaust historian, says the "crucial work" was published in 1920, in a book authored by two distinguished German professors titled *Die Freigabe der Vernichtung liebensunwerten Lebens* (*The Permission to Destroy Life Unworthy of Life*). The professors' arguments, often echoed in today's pro-euthanasia rhetoric, stressed euthanasia as a "healing treatment" and "healing work," calling for "death assistance" with the consent of patients, and advocated what current euthanasia enthusiasts now call protective guidelines, including a three-person panel to assess death requests.

That is not to say that advocacy of euthanasia was limited to Germany. The United States also developed a euthanasia movement. For example, in 1938, the Euthanasia Society of America was formed, to advocate voluntary, painless death to avoid "unnecessary suffering." This advocacy was not without appeal. One poll, taken in New York in 1941, seemed to indicate support by the public for voluntary euthanasia in certain cases.[6] The organization also had wider ambitions. According to a report in the New York *Times*, the Society also "hoped" to eventually expand euthanasia to include the involuntary killing of "nonvolunteers beyond the help of medical science."[7]

Whether the early euthanasia movement would have ultimately found public favor will never be known because of the unveiled horrors of the Holocaust after World War II. In the aftermath of German genocide, the world cried out for answers to the vital question: How could a civilized nation descend into such unmitigated evil and horror? Investigators soon concluded that Germany's pre-death-camp euthanasia, [8] and the life-cheapening ethic it spawned, helped pave the way for the killing of six million Jews and millions of others, including Gypsies, homosexuals, and religious minorities. Leo Alexander, a physician who investigated the Holocaust during the War Crime Trials at Nuremberg, wrote in the *New England Journal of Medicine*:

> Whatever proportions these crimes [of the Holocaust] finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally, all non-Germans. But it is important to realize that

> the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick.[9]

With the general populace understanding the evils and consequences of euthanasia, there was zero chance in the post-war years that euthanasia would be legalized. Consequently, the legalization movement became quiescent. It was, however, not (if you will pardon the pun) dead—euthanasia advocates had not given up their crusade, they were merely lying low until the heat had passed.

By the 1970s, memories of the Holocaust were fading and the euthanasia crusade was resumed, this time taking a more incremental approach. Realizing that "euthanasia" had become a discredited word, advocates changed the names of their organizations. In 1975, the Euthanasia Society of America became the Society for the Right to Die. The Euthanasia Educational Counsel became Concern for Dying. Ultimately, these groups which had once been united recombined to form today's "Choice in Dying," currently the primary pushers of "Living Wills." At about the same time (1980), Derek Humphry and his wife, Ann Wickett-Humphry, formed the Hemlock Society, soon to become the most energetic organization openly and actively pushing for legalized euthanasia.[10] (Humphry later became famous as the author of *Final Exit*, the book which popularized the plastic bag as a suicide tool. His writings can now be found on the Internet, under the name "Death Net.")

Euthanasia enthusiasts knew that people were acutely sensitive to issues of dying and killing. Thus, they methodically laid down a roadbed of euphemisms upon which to drive their legalization *blitzkrieg*. Words and phrases such as "deliverance" and "gentle landing" became the terms of choice instead of the truly-descriptive "killing." And "compassion" became the movement's by-word, an emotion on which advocates claimed a monopoly. A so-called "right to die" was invented whole cloth and euthanasia-ophiles moved to piggy-back their issue upon the abortion movement's success by adopting that most ubiquitous and successful of sound bites, "choice."

During this time, advocates in Holland were enjoying startling success; euthanasia was legitimized, first through court decisions and then by legislation. Euthanasia (killing by a doctor) and assisted suicide (patient self-killing with active assistance and supervision of a doctor) remain illegal, but if physiscians follow guidelines and report their activities to the proper authorities, they will not be prosecuted.

Back in the United States, as the 1990s dawned, euthanasia enthusiasts

believed that their time had finally come. People were angry—and afraid. Many believed that dying *inevitably* involves agonizing pain—a misperception that has gone uncorrected by euthanasia activists. In reaction to these fears, an increasing number of people seemed to want the "right" to have a doctor do them in. (This mistaken belief is understandable. While virtually all pain can be controlled or made tolerable, doctors—for various reasons—do a grossly inadequate job of alleviating their patients' pain. For example, up to 60 percent of physicians undertreat pain caused by cancer.[11]) Doctors were also perceived by many as "keeping patients artificially alive"—not for the benefit of their patients, but so as to be able to continue to collect fees from health insurance companies. Indeed, there is sufficient anecdotal evidence to indicate that such inexcusable medical exploitation does sometimes occur.

By 1988, euthanasia advocates believed that they had gained enough public support to successfully mount an initiative campaign to legalize doctor-killing of dying patients. Their target? The State of California. The vehicle? A planned initiative. But a problem developed. Supporters were unable to obtain enough petition signatures to qualify for the ballot.

The "death with dignity" crowd then focused on Washington State, where a measure (Initiative 119) qualified for the ballot in 1991. The proposed law would have authorized physicians to euthanize patients diagnosed with a terminal illness. Initial public opinion polls showed huge public support for the measure, running above 70 percent. The "death peddlers" were elated. It appeared that Washington was about to be the first jurisdiction in the world to formally legalize euthanasia.[12] But that was before the campaign. Once opponents revealed the proposed law's many dangerous flaws, such as the potential for involuntary euthanasia, Initiative 119 went down to defeat by a 54 to 46 percent margin, a loss of almost 30 percent in support from the initial polls.

Convinced of their own righteousness and undaunted by the unexpected defeat in Washington, activists decided to try again in California. This time they were able to gain enough petition signatures to qualify Proposition 161 for the ballot. As before, initial polling showed that the initiative was supported by a seemingly-insurmountable 74 percent of the electorate. But, as in Washington, it turned out that the more people learned about euthanasia, the less they liked it. In the end, Proposition 161 also failed, again by a 54 to 46 percent margin.

Why had these two measures, which seemed destined to easily succeed, ultimately suffered such profound collapses in public support? Dr. Robin Bernhoff, of Everett, Washington, a surgeon deeply involved in both cam-

paigns, believes that the public's seeming support for euthanasia is shallow and comes with great reservations: "When people are given the opportunity to consider how badly euthanasia would backfire in practice," he says, "they lose their enthusiasm very quickly. People facing the propositions were terrified of abuses and came to realize that there is no way to write safeguards that will protect medically, emotionally, and socially vulnerable people against premature death." Charles L. Cavalier II, the campaign strategist behind the defeat of Proposition 161, agrees: "Our initial polling indicated that while support for 161 and euthanasia in general appeared strong, in actual fact it was shallow and weak. The campaign slogan, 'No Real Safeguards,' struck a responsive chord. People came to realize that there is no safe way to legalize euthanasia."

The Subterfuge

Licking their wounds but not willing to give up the fight, the disappointed crusaders decided to try yet again in 1994. This time they focused on Oregon, where the Hemlock Society has its national headquarters. Oregon is well known for "libertarian" tendencies *and* low church-attendance rates—just the state, advocates believed, where they could breach the dike and unleash a flood of laws legalizing euthanasia across the country.

But they still faced a big problem: California and Washington had also seemed ripe for the picking, but support had collapsed. What could be done to prevent a similar result in Oregon?

Rather than spit into the wind of reasonable public fears about abuses, proponents decided instead to bend like the willow tree. An early version of the proposed initiative had been written looking very much like Initiative 119 and Proposition 161, that would have permitted doctors to fatally inject their patients. Instead, the new measure would only permit a dying competent adult to "request" a physician to "prescribe medication for the purpose of ending his or her life."[13] The only people "qualified" for physician-assisted death would be those suffering from a terminal disease, which was defined as "an incurable and irreversible disease" that "within reasonable medical judgment" will produce death within six months.[14] This proposition, unlike its predecessors, would be sold as a measure restricted to permitting physician-assisted suicide—while prohibiting physician-performed euthanasia—a law that would be peddled as being available only to competent adults who were very near death.

So-called "Safeguards"[15] were also written into the law, including disclosure of alternatives to suicide, a second opinion of a diagnosis, and a determination that the request was "voluntary." A 15-day waiting period

was added, as well as a provision requiring referral to counseling for patients suspected of suffering from depression. More, patients wanting to die must make two oral and one written request before the drugs to be used in the suicide are prescribed. The patient has a right to rescind the request. Finally, the patient is to be requested by the doctor to notify the family, although the suicide can proceed even if the patient wants his or her family kept in the dark.

These "protections" were designed to mask the truly radical step that Oregonians were being asked to take in Measure 16. A close look at the actual wording of the initiative reveals that the safeguards are, in reality, so much smoke and mirrors.

Fallacy #1: Only the Truly Dying Qualify

Measure 16 proponents insist that the only people eligible for doctor-hastened death are people at or near the brink of death. Not true. Recall that the law defines terminal illness as "*an incurable and irreversible disease that . . . will, within reasonable medical judgment, produce death within six months.*"[16] Note that there is nothing in the definition requiring that death will occur "even with treatment" or other such language to weed out people who will not be likely to die if they receive proper medical care. That means diabetics who require insulin, people who need kidney dialysis, or those dependent on a feeding tube to receive nutrition—to name just a few—suffer from terminal conditions under the law.

Measure 16's definition of terminal illness ignores the fact that doctors are rarely able to accurately predict when a person will die. Many patients who have been diagnosed as terminally ill with six months to live outlive the time period by many months or even years. (The author's father is one such patient. He suffered from colon cancer. At one point, he was diagnosed by two doctors as having only a few months to live. Depite this, he lived for another 16 months, most of them in relatively good condition, allowing him to travel, go fishing, and generally enjoy life.) Indeed, many patients with a prognosis of death within six months never die from their diagnosed "terminal condition" at all.[17]

Fallacy #2: Doctors Are Prohibited from Killing Patients

Opponents of Initiative 119 and Proposition 161 effectively exposed the dangers of doctors being empowered to kill their patients. Realizing this, Measure 16 authors sought to overcome this objection by providing that "*nothing in this Act shall be construed to authorize a physician or other person to end a patient's life by lethal injection, mercy killing or active*

euthanasia. Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide under the law."[18]

Measure 16 may not "authorize" physician killing, but there is no *specific prohibition* against physician—or third party—administration of the lethal dose in the initiative. This is a remarkable omission. If the intent was truly to prevent doctors from killing patients, why not come out and specifically say so? Besides, what drug may a doctor prescribe but not also administer? There is none.

Fallacy #3: Depressed Patients Are Protected

The authors of Measure 16 wanted people to believe that depressed patients would be weeded out and sent to counseling before being allowed assistance with suicide. As usual, however, the promise was not supported by the terms of the initiative. While it requires doctors to refer depressed patients for "counseling,"[19] the law's definition of "counseling" provides virtually no protection for vulnerable patients: Counseling means *a consultation between a state licensed psychiatrist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.*

Note that Measure 16 does not mandate a formal psychiatric evaluation of the type required to accurately diagnose depression. Even if depression is diagnosed, there is absolutely no requirement that it be *treated.* Moreover, since depressed patients are not prevented from killing themselves, so long as they do not have "impaired judgment," a vague and undefined legal term, the suicides of depressed people are very likely to take place if the law ever goes into effect.

As if the scant protection accorded by the counseling clause is not weak enough, it is further undermined by the reality of medical care for those diagnosed with terminal illnesses. The medical literature makes it clear that most doctors are inept at identifying depression in their patients, especially patients thought to be dying. For example, the New York Task Force on Life and the Law studied the issue and issued a unanimous recommendation against legalization. One reason: "Depression is frequently underdiagnosed and undertreated, especially for the elderly and for patients with chronic or terminal medical conditions."[20]

This unfortunate truth bodes especially ill for vulnerable people under Measure 16. First, many depressed people will likely slip through the Oregon suicide machinery without referral to a mental health professional, even if profoundly depressed, since even acknowledged depression may not be

deemed by the suicide doctor to affect their ability to make an "informed decision." Second, even those depressed patients who were referred for counseling would likely find that activity merely a "going-through-the-motions." This is especially true because of the likelihood that mental-health professionals who would be doing the counseling would be sympathetic to the "rational" choice to end life. Unless a patient is deemed legally incompetent and unable to make an unimpaired judgment, it is highly doubtful that the counseling requirement of Measure 16 would accomplish anything substantive for depressed, suicidal patients. Indeed, the counseling requirement is so underdefined that, even if ordered, counseling could amount to nothing more than a one-hour conversation about the "rationality" of choosing death. And since the "counseling" could occur during the 15-day waiting period, there might not even be a delay in the deaths of depressed people. (This is especially unfortunate: according to the New York Task Force, once depression is accurately diagnosed and treated, the desire of the dying to hasten their deaths evaporates in almost every case.)[21]

Fallacy #4: Only Oregon Residents Could Qualify

Measure 16 does state that only Oregon residents qualify for assisted suicide, but that protection is less than meets the eye. What does it take to become a "resident" of the state? Not much. Merely establishing an address and proclaiming residency in some fashion will often suffice. Thus, a suicidal person could move to Oregon and find a "death doctor" who "specialized" in assisted suicide. (The names of such doctors would quickly become known in the euthanasia community, which would no doubt publicize their names.) The death doctor, upon being given an Oregon address, would quickly diagnose the terminal condition and refer the patient to a colleague of similar bent for a fast second opinion. Fifteen days later, within a few weeks of "moving" to Oregon, the death-dose could be supplied and the patient could be dead. Moreover, even if the patient consulted with the most conscientious of physicians, the doctor would be unlikely to check into the legality of the patient's claimed residency, meaning that non-Oregonians bent on suicide could easily obtain "assistance" under Measure 16.

With so much missing, Measure 16's guidelines can hardly be called "strict." Nor do they protect. What they do is falsely assure. But of course, that is the whole point.

The Campaign

Both sides in the debate entered the Measure 16 campaign with logical

reasons for optimism. Opponents, buoyed by the results of the victories in Washington and California, believed that with an appropriately hard-hitting campaign, the people of Oregon would also reject physician-induced death. For their part, proponents believed that the measure's minimizing had sufficiently weakened the abuse issue which had been so potent against their cause in the past. Besides, initial support for the initiative was in the high 60 percent range. Derek Humphry, co-founder of the Hemlock Society and major backer of legalized euthanasia, was especially excited, writing in a fund-raising letter for the initiative: "A break-through in Oregon will start a domino effect of law reform on assisted dying throughout America."

The "Yes-On-16" campaign led by Oregon Right to Die wasted no time in getting to a hard-hitting, emotion-driven appeal. Their poster-woman was a nurse named Patty Rosen, head of a chapter of the Hemlock Society. In commercials, Rosen claimed to have helped her daughter, who was suffering from agonizing bone cancer, to kill herself some years earlier—she called herself a "criminal" because she had obtained the pills for her pain-wracked daughter, asserting that she had done so because her daughter "couldn't bear to be touched." Her voice cracking with emotion, Rosen said "... as she slipped peacefully away, I climbed into her bed and I took her in my arms for the first time in months...." It was a poignant, touching ad that left few viewers unmoved, fewer still thinking about the vital issues of the campaign, such as abuses, societal consequences, or whether doctor-induced death would really reduce human suffering.

Emotionalism and fear-mongering about suffering and death were not the proponents' only tactics. They also appealed to Oregon voters' reputed parochialism, mixed in with Catholic bashing.

This was not an illogical approach: the Catholic Church was very closely associated with the "No-On-16" campaign, providing funding to the opposition, and clerical-collared churchmen were often pictured by the media expressing anti-Measure 16 sentiments.

Unfortunately, such close association may have helped in the measure's passage. Richard Doerflinger, an official of the National Conference of Catholic Bishops, says Oregon has something of an anti-Catholic history. For example, in 1992, Oregon banned Catholic parochial schools by requiring every child to attend public school. The law was later confirmed by public referendum but was eventually overturned by the U. S. Supreme Court.[22]

Whether or not Oregonians are anti-Catholic in significant numbers, the "Yes-On-16" campaign acted as if Catholic opposition was a plus for their

side. One impliedly anti-Catholic ad asked: "Are we going to let one church make the rules for all of us?" Another notable radio commercial was more specific in its anti-Catholic appeal:

> Who do you politicians and religious leaders think you are, trying to control my life? It's none of your business, so back off and back off now. I'm voting yes on 16 because what we have are some politicians and religious leaders who are playing politics all getting together to control my life. Listen, if I'm terminally ill, I don't want my family to be forced to drain their savings for unnecessary costly medical care while I suffer just because the politicians and religious leaders say that's the way it has to be. And don't buy the garbage the Catholic Church is putting out. The safeguards in 16 are as long as your arm. Multiple medical opinions, two oral requests and a written request that can be canceled at any time, a 15-day waiting period and another 48-hour waiting period. You know, there are just some people who believe they have a divine right to control other people's lives, and they'd better back off because it's none of their business.
>
> —Paid for by Why Don't You Busybodies Butt Out and Allow Us to Make Our Own Decisions Committee.[23]

Another ad complained that Catholic money was financing the opposition, stating:

> Their opposition is theological. They believe suffering is redemptive and that preserving physical life is always valued higher than relief of suffering, no matter how humiliating and intolerable that physical life is. And they apply that standard not only to themselves but to every Oregonian. They want to impose their unique theological perspective on the entire state.[24]

If recent American political history proves anything, it is that such negative ads work. Yet, in contrast to the proponents' hard-ball, pull-out-all-the-stops advocacy, the opposition forces, led by Pat McCormick, a political consultant who headed the Coalition for Compassionate Care (CCC) took a far more "whiffle-ball" approach. CCC never got "down-and-dirty." Oh, it ran a fine commercial of a woman who had been misdiagnosed as being terminal within six months, warning of mistakes if Measure 16 passed, and financed ads responding to the false charge that it was only the Catholic Church that opposed the initiative.[25] But the campaign did not go for the emotional jugular vein, as the opposition to Initiative 119 and Proposition 161 had, with vivid, hard-hitting television and newspaper ads illustrating the potential abuses—and horrors—of Measure 16.

This lack of punch puzzled many observers. Alarming people with legitimate warnings about the potential for abuses had effectively turned the tide in the other states. In California, Cavalier and Associates created an award-winning television ad depicting a Kevorkian-looking doctor entering an elderly woman's room, carrying a euthanasia-syringe with which to kill her. That ad resonated with voters, causing support for Proposition

161 to drop like a crowbar thrown off a bridge. Yet no similar advertisements were run against Measure 16, despite the unfortunate fact that the CCC campaign was never able to reduce support for the measure beneath the crucial 50 percent mark.

Critics contend this go-soft approach was a form of unilateral political disarmament which led directly to the measure's narrow passage. One experienced political strategist who watched the campaign closely (speaking on condition of anonymity) is convinced that Measure 16 could have been defeated: "For whatever reasons, the opposition campaign decided to softball their campaign," he says. "They simply chose not to use their most potent arguments, even though history proves that these arguments work."

Perhaps the most vocal critic of the "No-On-16" campaign is Rita Marker, executive director of the International Anti-Euthanasia Task Force, a non-profit group dedicated to educating the public on issues related to the euthanasia debate. Marker, one of the world's pre-eminent experts on the subject, has spent 13 years researching and writing about euthanasia issues in the United States and internationally. She remains angry that opposition to Measure 16 was so ineffective: "When someone takes on the responsibility of defeating a measure," Marker believes, "and says, 'I will lead and I will direct all that needs to be done,' they had better do it and do it well. Unfortunately, the opposition took on the responsibility and then engaged in political pacifism. As the leader of the campaign, that was irresponsible. For all appearances, it seemed they were more concerned with being nice to political opponents rather than protecting the lives of those who will be victimized by this law."

This lack of aggressiveness is perhaps best illustrated by a crucial lapse during the critical last week of the campaign. Information surfaced that Patty Rosen had been, to put it kindly, disingenuous about the death of her daughter in her commercials. Rosen stated that her daughter had died from taking an overdose of pills. But a tape recording of a Rosen speech made two years previously (on behalf of Proposition 161) revealed that she had actually given her daughter an *injection* because she feared the pills were not going to work.

Here was an opportunity rarely found in campaigns of this sort. If Rosen's credibility could be legitimately destroyed in the minds of voters (she admitted in a newspaper article that she had given her daughter an injection), then so could Measure 16. An ad could have asked the question "What else aren't they telling you about Measure 16?" or "Measure 16,

you haven't been told the truth!" to make voters feel uncomfortable about supporting a law whose proponents could not be trusted.

But no such ad was created (even though the campaign still had money in the bank), nor was Rosen's gaping credibility gap exploited by CCC, even though Pat McCormick was well aware of her deception. Indeed, as the opposition campaign limped to its conclusion, little mention was made about Rosen's truth-telling problem except in a few low-key, inside-page newspaper stories.[26]

In the end, it was a tragic matter of so-close-yet-so-far. Not quite 100 years after the publication of *The Right to Death*, a bare 51 percent of Oregon's voters formally gave a sovereign state's *imprimatur* to physician-assisted suicide. (Pat McCormick was called for comment about the "No-On-16" campaign and the criticisms leveled against it. He did not reply.)

The Aftermath

In the aftermath of passage, reality hit Oregon. By its terms, the law was to go into effect last December 8. Yet no one knew how the law would be administered. The Oregon Death With Dignity Task Force was quickly created to work though the details of implementation. Despite the fact that membership specifically excluded the law's opponents,[27] the Task Force was unable to reach agreement on even the seemingly-simplest of tasks, such as defining Oregon residency, or the cause of death to be listed on the death certificate of a person who died under the provisions of the law.[28] (Recall that, in an amazing leap of illogic, the law specifies that an assisted suicide is not to be considered a suicide—yet it is still not a natural death!)

Concurrently, a lawsuit was filed challenging the legality of Measure 16, brought by several terminally-ill citizens, their doctors, and one diabetic, who obejcts to the definition of the terminally ill in Measure 16 as apparently including people who would not die if provided proper medication or other treatment.[29] The plaintiffs contend that Measure 16 unlawfully deprives those who suffer from "the disability of a terminal disease" of the law's protection against suicide afforded other persons under Oregon law, in violation of their right to equal protection in the U.S. Constitution. (For example, under Oregon law, a police officer is authorized to use force to prevent a suicide.) The plaintiffs also argue that the measure violates the Americans With Disabilities Act, and that the law is impermissibly vague.

With so much at stake, and much to the consternation of Measure 16

supporters, U.S. District Judge Michael Hogan granted plaintiffs' request for an injunction prohibiting the law's implementation. In explaining his decision, Judge Hogan wrote:

> Death is overwhelmingly final and not the subject of reversal, mitigation or correction. Although death may be viewed as a release from suffering, it is nevertheless the end of life and therefore, the legal equivalent to an injury to life. Death constitutes an irreparable injury and I find that the possibility of unnecessary death by assisted suicide has been sufficiently raised to satisfy the irreparable harm requirement for a preliminary injunction.[30]

This does not mean that Measure 16 has been declared unconstitutional. Far from it. Rather, the Court's ruling only means that it cannot go into effect pending a trial which will determine the law's constitutionality, and whether federal law pre-empts the measure. (Proponents have appealed the preliminary injunction; as this is written, that matter is pending before the Ninth Circuit Court of Appeals and the law remains in limbo.)

Measure 16's passage was also used by the "death with dignity" crowd to create an illusion that assisted suicide laws are inevitable and that euthanasia is a public policy whose time has come. Clones and near-clones of the measure were quickly introduced by euthanasia-sympathetic legislators in California, New Mexico, Colorado (ironically by the sister-in-law of ex-Gov. Richard "Old People Have a Duty To Die and Get Out Of the Way" Lamm), Massachusetts, Wisconsin, New Hampshire, and Maine. New Measure 16-type initiatives are also threatened in several other states.

Passing these laws may prove more difficult than originally thought by proponents, thanks in large part to Derek Humphry himself. Unable to restrain his enthusiasm, he too quickly revealed the next step likely to be advocated in the euthanasia movement's drive to legalize doctor-induced death. Within a month of Measure 16's passage, Humphry actually criticized it to the New York *Times*, despite his enthusiastic support of it only a few weeks earlier. In Humphry's opinion, Measure 16 is potentially "disastrous." Why? Because it does not specifically permit physicians to kill patients:

> Evidence I have accumulated shows that about 25 percent of assisted suicides fail, which casts doubts on the effectiveness of the new Oregon law, although it remains a significant demonstration of public opinion. The new Oregon way to die will only work if in every instance a doctor is standing by to administer the *coup de grace* if necessary.
>
> The only two 100 percent ways of accelerated dying are the lethal injection of barbiturates and curare or donning a plastic bag. I prefer the injection.[31]

Not surprisingly, in keeping with the duplicitous nature of the pro-Mea-

sure 16 campaign, this information went undisclosed to the people of Oregon before election day.

A Dangerous Future

The saga of Measure 16 is a case study in cynicism and subterfuge. The backers of the initiative knew that Oregonians would reject any measure that appeared to be an outright legalization of euthanasia, as voters had done in California and Washington. So they wrote the proposal in minimalist terms, hoping to hide the radical scope of their real agenda, to fool voters into believing that the measure would "only" permit physician-assisted suicide. But as Humphry's letter makes clear, the initiative is intended by its authors to be the rock that starts the avalanche down euthanasia's slippery slope, an avalanche designed to obliterate 2,500 years of civilized policy prohibiting doctor-induced death.

This is not a matter of conjecture, nor is it alarmist. The social and moral consequences of legalizing doctor-induced death are plain. Historically, they can be seen in all of their awful horror in the Holocaust. Today, they are being experienced in the current slide of Holland down that slope.

The Dutch experience reveals the future of the United States if euthanasia advocates here succeed in legalizing killing by doctors or assisted suicide. Holland's descent into euthanasia can be traced back to 1973, when a Dutch judge refused to punish a doctor who had been convicted of killing her ailing mother by lethal injection. The judge ruled that the defendant had stayed within certain informal policy "barriers" against patient abuse. Thus, he ruled, no legal sanction should apply. (The convicted physician was sentenced to a short probation.)

That case, and others like it, led directly to the current state of Dutch law, which technically prohibits doctor-induced death but permits euthanasia to go unpunished if physicians stay within legislatively-written guidelines, under which only patients who repeatedly and voluntarily request death, and those experiencing unbearable pain, are supposed to be killed. In actual practice, however, Dutch physicians routinely ignore the rules. Here is just a partial sample of what is happening in Holland, a mere 21 years after euthanasia made its first legal breakthrough:

- According to the Remmelink Report, a government-sponsored survey of euthanasia practices, more than 1,000 patients a year are *involuntarily* euthanized, that is, doctors kill on average three patients a *day* without permission or without even discussing the matter with the patient or family.[32]

- Dutch people are euthanized who are not even terminally ill. Indeed, they do not have to be *physically* ill. For example, the Dutch Supreme Court recently ruled that a psychiatrist acted properly when he "assisted" his physically-healthy patient's death, ruling that the action was justified by the patient's severe depression. (The woman's two children had died and her marriage had dissolved.)[33]
- Babies born mentally retarded or with birth defects are being killed in their own cribs by pediatricians. Indeed, the Dutch Pediatric Association is drawing up guidelines for the practice of infant euthanasia.[34]

All of this and more, arising from one case allowing a doctor to go unpunished for a "mercy killing."

The Dutch experience demonstrates this truth: once euthanasia and related practices are set in motion, they never stop expanding. This is the slippery slope. It is insidious. It is inexorable. It is real.

Will Measure 16 be a jumping-off point from which our society is "Hollandized" into accepting a virtual death-on-demand ethic, with its attendant consequences to the old, the infirm, the dying and the depressed? Or will Measure 16 ultimately be remembered as a mere footnote to history, an uncharted path briefly trod upon but quickly abandoned in the name of ethics, morality, dignity, compassion and plain old human decency?

How we answer these questions will tell us much about our collective belief in the dignity and sanctity of human life and the ethical course we will take as a nation. Moreover, our decisions will have a material impact on much of the world. After all, if we can export the morality and values of pop culture, we can certainly export the ethics of Jack Kevorkian.

NOTES

1. Robert Jay Lifton, *The Nazi Doctors* (New York: Basic Books, 1986), p. 27.
2. *Medical Decisions About the End of Life* (the Hague, the Netherlands: 1991), hereafter *The Remmelink Report.*
3. The official title of Measure 16 was "The Oregon Death With Dignity Act."
4. In the traditional Hippocratic Oath, named after the ancient physician Hippocrates, physicians pledge to "never give a deadly drug to anyone if asked nor suggest such counsel."
5. *The Nazi Doctors*, pp. 46-47.
6. Rita Marker, *Deadly Compassion* (New York: William Morrow & Co., 1993), p. 38, citing the New York *Times*, January 27, 1937.
7. Id.
8. *The Nazi Doctors*. The first euthanasia victim of the Holocaust is thought to be a baby born with birth defects. His mother petitioned Chancellor Adolf Hitler for permission to have the baby killed by a doctor. Hitler instructed his personal physician to investigate and oversee the euthanasia upon having the facts confirmed.

9. Leo Alexander, "Medical Science Under Dictatorship," *The New England Journal of Medicine*, July 14, 1949.
10. *Deadly Compassion*, pp. 43-44.
11. *When Death is Sought*, the New York Task Force on Life and Law, 1994. A New York task force appointed by Gov. Mario Cuomo, which, after an intensive investigation of the issue, unanimously recommended against legalizing euthanasia or physician-assisted suicide.
12. Despite the hundreds of thousands of deaths, euthanasia was never actually legalized in Nazi Germany. As described in the main text, euthanasia is also technically illegal in the Netherlands, although it is routine.
13. The Oregon Death With Dignity Act, § 2.01.
14. Id. § 1.10 (12).
15. Id. Section 3 is entitled "Safeguards."
16. Id. § 1.10 (12).
17. For exaqmple, see Geoffrey Cowley, "Surviving Against All Odds," *Newsweek*, March 13, 1995.
18. Death With Dignity Act, § 3.14.
19. Id. § 3.03.
20. *When Death Is Sought*, p. 175.
21. Id., p. x.
22. *Pierce v. Society of Sisters*, 268 U. S. 510 (1925).
23. Transcript provided by National Conference of Catholic Bishops, Secretariat for Pro-Life Activities.
24. KGW News, October 12, 1994.
25. Many religious organizations, in addition to the Catholic Church, opposed Measure 16, most notably the Ecumenical Ministries of Oregon, made up of a broad cross-section of churches in Oregon, including the African Methodist Episcopal Church, the Episcopal Church, the Greek Orthodox Church, the Society of Friends (Quakers), the Church of Jesus Christ of Latter-Day Saints (Mormons), and the United Methodist Church. Among the many non-religious opponents of Measure 16 were the Oregon Hospice Association, the Oregon Pharmaceutical Association and the Portland *Oregonian* newspaper. Unfortunately, the Oregon Medical Association remained neutral during the campaign.
26. For example, see the *Oregonian*, November 4, 1994, p. C1.
27. Diane Dietz, "Law on Suicide Evolves Slowly," *Statesman Journal*, December 2, 1994.
28. Id.
29. *Lee v. State of Oregon*. In the United States District Court for the District of Oregon, Civil No. 94-6467.
30. Id. "Opinion and Order Granting Preliminary Injunction," December 27, 1994.
31. New York *Times*, letters to the editor, December 2, 1994.
32. *Remmelink Report*. The *Report*, based on physician surveys, was named after the director of the study, Professor Jan Remmelink.
33. Herbert Hendin, "Seduced by Death: Doctors, Patients and the Dutch Cure," *Issues in Law and Medicine*, vol. 10, no. 2, Fall 1994.
34. Maurice A. M. de Wachter, "Euthanasia in the Netherlands," *The Hastings Center Report*, March-April 1992.

The New Ireland *vs.* God

David Quinn

George Orwell and Franz Kafka may be dead and gone, but their spirits live on in the Ireland of 1995. Perhaps, by the time you finish reading this, you will understand why.

Our legislators have just voted into law a bill which will in time pave the way for legalised abortion on demand on this island. The bill is called "The Abortion Information Bill," and it will turn abortion into an acceptable option for reasonable people.

We are now in the truly bizarre situation of having in place, side by side in our Constitution, a clause protecting the right to life of the unborn, and another saying, in effect, "but if you do want to have an abortion, here's how to go about it." In its absurdity, it's not too unlike enacting a law which on the one hand forbids the taking of heroin, and on the other, gives you the names and addresses of drug pushers. In short, we now have what is known here as "an Irish solution to an Irish problem," of which more later.

Before going any further, however, it might be just as well to ask how we got ourselves into this situation.

Readers of this journal are undoubtedly more familiar than most with what has become known as the "X Case." In 1992, a 14-year-old Irish girl was prevented from going to England to have an abortion. Her neighbor, a middle-aged man who used to baby-sit her, had sex with her several times over a series of months. Under our law, because she was underage, this is known as "Unlawful Carnal Knowledge." In other jurisdictions it is called statutory rape. For some, it is simply rape.

Upon finding out she was pregnant, her parents took her to England for an abortion. They approached the police here to see if they would accept, as evidence against the rapist, DNA from the aborted foetus. Confronted with an actual case of people intending to do in England what is illegal here, the police referred it to the Attorney General, who declared it would be unconstitutional for her to go to England for an abortion.

When this decision became known, all Hell broke loose. The rest, as they say, is history. There was an international scandal. We caused more outrage than Pol Pot's Cambodia or Ceausescu's Romania. In fact, it says

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a lot about the western world's values and priorities that such opprobrium was heaped on us, urged on eagerly by our own Irish media.

In the event, and not surprisingly, the Supreme Court overturned the Attorney General's decision on the ground that the girl was "suicidal" and therefore the pregnancy was a threat to her life. Under our Constitution the life of the mother must be balanced against the life of the unborn child. In deciding that the girl was suicidal, the Court accepted the expert testimony of a single doctor.

The judges took it as a given that pregnant women commit suicide as a result of being pregnant. Also, against evidence to the contrary, they accepted that an announcement of intent to commit suicide is a good predicator of suicide itself.

Some months later, in November, 1992, on the same day as a General Election, a constitutional referendum was held and the people voted in favour of the right to travel, and in favour of the provision of abortion information.

Meanwhile, the man at the centre of the X case was eventually sentenced to 14 years imprisonment, of which, again, more later.

In March of this year—more than two years after the referendum—the Government finally brought before the Dail (our parliament) a bill laying down the law on abortion information. It boiled down to this: while a doctor could not actually make an appointment for a woman with an abortion clinic in England, he could provide her with the names and addresses of those clinics if she was determined to end her pregnancy. Doctors could also now discuss with the woman all the options available to her, including abortion, but they could not *recommend* an abortion. In other words, the bill allowed for what is disarmingly called "non-directive counselling," another concept readers of this journal may be only too familiar with.

Upon publication of the bill, once again all Hell broke loose. Not as much Hell as last time, mind you, but bad enough all the same.

Pro-choice advocates were fairly pleased with the bill since it was a piece of legislation which, only a few short years ago, would have been unthinkable. They did feel it was a bit much, though, that doctors could not pick up the phone and actually make the appointment for their patients. This, they felt, represented an unacceptable invasion of the doctor-patient relationship. The fact that when a pregnant woman appears before a doctor, he is dealing with two patients and not one, impressed them not in the slightest. This was a mere detail. Much better to sweep it under the carpet and ignore it.

On this occasion, most of the fuss was generated by pro-life groups, ably led by the Pro-Life Campaign, and the consequent outrage expressed by the media that anyone should have the temerity to exercise their democratic rights by lobbying their politicians so intensively.

The specific objection of the pro-life groups was that the provision of names and addresses was tantamount to referral, and that when the information amendment was put before the people, they were specifically informed it would *not* allow this.

The coalition government of 1992, led by our main party, Fianna Fail, was pretty tricky. They never made clear what "referral" or "information" meant. So everyone went into the ballot box thinking they knew what they were voting for, having decided for themselves what referral and information meant.

By leaving these words undefined, the previous government allowed the present coalition government, led by Fine Gael, the luxury of being able to put their hand on heart and claim with all sincerity that regardless of their personal feelings, they were merely enacting the will of the people. At the same time, the Pro-Life Campaign could put their own construction on the words, and claim with equal sincerity that the government was not enacting the will of the people, since the people never *voted* for referral.

For my part, I think logic is on the side of the Pro-Life Campaign. If I consult a doctor, and he says he cannot help me, but instead gives me the name and address of someone who can, that is referral by any other name. The doctor has "referred" me to someone else. But as far as the government is concerned, referral only takes place if the doctor makes the actual appointment. As I said earlier, the spirit of Kafka is alive and well in modern-day Ireland.

There is another twist to the tale. Thanks to the lobbying efforts of the Pro-Life Campaign, Fianna Fail, the party (if you recall) which was in power at the time of the 1992 referendum, decided to vote *against* the information bill, even though the bill as enacted was actually *less* liberal, and not more, than the bill they intended introducing prior to their being unceremoniously dumped from office at the end of last year. Yes indeed, the spirit of Kafka is howling like a banshee in the Emerald Isle.

Anyway, if I haven't lost you yet through sheer boredom, then cheer up. Here's where it gets exciting. At this point in the drama, one Mr. Justice Rory O'Hanlon enters stage right and really upsets the liberal establishment. Rory O'Hanlon is a member of Opus Dei, which in this country is tantamount to being in the Communist Party in 1950s America. We're

about two steps away from setting up a McCarthy-like Committee of Enquiry to hound such undesirables into extinction.

In a way, Mr. Justice O'Hanlon is the stuff of which liberal nightmares are made. A committed, orthodox Catholic sitting on a judicial bench in the second-most important court in the land, the High Court. Not only that, but when he speaks on moral issues, as is his wont, he uses what is to liberal ears the most appallingly old-fashioned language. On this occasion, moved by conscience to intervene in the abortion debate, he invoked the authority of God *and* "the Most Holy Trinity" to justify his opposition to the information bill. In point of fact, for good or ill, our Constitution explicitly invokes that self-same authority.

In a reply by Michael McDowell, M.P., in the *Irish Times* the next day, O'Hanlon was condemned for seeking to impose Catholicism on those of differing beliefs: "The ultimate logic of his position" wrote McDowell, "is that the majority view on abortion is secondary to the views of those who claim to know God's view on the matter. And that is a position of Catholic absolutism."

For presuming to speak on behalf of Muslims, Jews, and Protestants on this issue, a *Times* editorial, appearing on the same day as McDowell's article, sniffed "What is disquieting in Mr. Justice O'Hanlon's statement is his assertion that those of every religious belief in this society . . . must share his Catholic view on abortion." The next day the *Times* published a front-page cartoon depicting a man being acquitted by a judge declaring "Sorry . . . I don't recognize the laws of this country . . . I only accept the supreme judgement of God."

Some days later, one of our liberal Catholic theologians joined the chorus, condeming O'Hanlon for trying to turn Ireland into a confessional state. His comments were carried on the front page of the *Times*. Surprise, surprise.

The *Irish Times* is our equivalent of the New York *Times*. It is politically-correct down to its bootstraps. But it is easily Ireland's most influential newspaper. There are politicians and bishops who live in fear of a stinging rebuke from an editorial or from one of its columnists. The *Times* prides itself on its urbanity, its liberalism, its tolerance, and its intelligence.

In fact, in a generous mood, and at a push, I would at most be willing to concede that the *Irish Times* is urbane. However, it is not liberal except in the most narrow, modern sense. Rather, it espouses a form of radical, disengaged individualism. It is not tolerant. Instead it plays hardball. Anyone who opposes it is not just wrong, but wicked. It has very successfully

demonised and dehumanised all of those who have had the temerity to challenge its agenda.

As for being intelligent, I would say it is so long since the *Times* thoroughly examined its presuppositions that it would not recognise a presupposition if it fell over it.

Its response to O'Hanlon provided ample evidence of this; it seemed blissfully unaware that by placing the law of the state above all other sources of the law—under all circumstances—it was cutting out from under itself the grounds for ever opposing the state over anything. In fact, it was tacitly admitting that the Nazi defense at Nuremberg was watertight, since the Nazis relied for their defense on the fact that they were merely obeying the law of the land.

In addition, the *Times* managed successfully to cut itself off from ever again appealing to individual conscience as a ground for opposing the law of the state. To jettison all consideration of God from the law is to elevate the state above the individual, a very strange thing indeed for a liberal paper to do.

Of course, the *Times* would deny that it did any such thing. But as I say, that's because *Times*men are no longer in touch with their own presuppositions, and in any case, any argument will do just so long as it defeats the hated "fundamentalists." No matter if at some future point they are inconsistent enough to turn around and support the right of the individual against the state: Who's going to *notice* such a little act of hypocrisy anyway?

That the *Irish Times* should fret over O'Hanlon's implying that everyone should share his Catholic views is also a bit rich. After all, hasn't the *Times* been trying for years now to convert us all to the "personal autonomy" ethic? Also, we must all be feminists now, whether we like it or not, if necessary under force of law.

It is probably pushing things a bit, though, to call the *Irish Times* "Orwellian," although the manner in which it favours big government would delight the pigs in *Animal Farm*. But certainly the spirit of Orwell lives and moves and has its being in the corridors of Leinster House (our parliament building), and it has positively possessed the pro-choice movement.

There are three big lies being told in Ireland at present. The first is that we have the highest (or one of the highest) abortion rates in Western Europe. The second is that by providing women with information and advice on abortion in a "free and open manner," we will *reduce* our abortion rate.

The third is that the pro-abortion movement isn't really pro-abortion at all, but is in reality pro-life.

The first lie is now accepted by smart opinion as "one of those things everyone knows." Various newspapers, as well as our national and monopolistic broadcasting service (RTE), have been spreading it about with great relish.

The worst offender of all, however, has been our Minister for Health, Michael Noonan, the poor unfortunate who was charged with the unenviable task of pushing the abortion information bill through parliament. In my own column in *The Sunday Business Post* I wrote:

> That our abortion rate is in fact much lower than Britain's might surprise those who have been listening to RTE and some of our politicians telling us otherwise.
>
> Our Minister for Health for one appears to believe our rate is the highest for Western Europe. He has said so several times. Perhaps he might be more accurately called our Minister for Disinformation because he has the greatest difficulty grasping the simplest facts, in particular anything to do with statistics. Let me demonstrate:
>
> - In 1989 there were 751,205 live births in Britain. In the same year some 181,410 abortions were carried out on British residents. That works out at 24.1%.
> - In Ireland in 1992, there were 50,000 live births and approximately 4,000 women travelled to Britain to have an abortion. That works out at 8%.
> - For some reason, in the mind of our Minister, 8% is higher than 24%. Do you wonder now why I am worried about his mathematical ability?

Obviously I am the least-influential columnist in the country, because he never retracted his claim, and the media continues to spread it about.

The second lie, that by providing information on abortion we will reduce the abortion rate, is even sadder, more pathetic, and more insidious. Britain has been awash with abortion information for years now, and in the time since abortion was legalised there in 1967, the number of abortions carried out in England and Wales has increased from some 23,500 per year to over 170,000 in the past year.

Again, quoting my good self, I had this to say in my column:

> When something becomes an acceptable option for reasonable people, it is foolish in the extreme to expect it to become less widespread. Almost always the exact opposite will occur. By placing the abortion option on the same moral plane as adoption or keeping the baby, the bill will cause the trendline to end up here as it did in Britain. It might take a few years, but it will happen.

More sinister and more Orwellian than anything else, however, has been the doublespeak of pro-choice advocates. "We're not pro-abortion," they exclaimed, "We think abortion is abhorrent. We are pro-life. We want to reduce our abortion rate. That is why the bill must be passed. Being able

to talk freely about abortion to women contemplating the trip to England will enable us to find out why they think abortion is their only choice. If we can find out why they go to England, then maybe we can do something about getting the rate down."

Readers of this journal won't need to be told how this argument flies in the face of all available evidence to the contrary. Not only is it an exercise in self-delusion, it also attempts to break down in people's minds the difference between the pro-life position and the pro-choice position. Which is of course precisely the aim of doublespeak. Actually, during the recent debate, the media began referring to the Pro-Life Campaign as the "so-called" Pro-Life Campaign, clearly implying that pro-choice advocates have at least as strong a claim to being pro-life.

The government has now completely bought into the big lie. Plans to introduce sex education in Irish schools are now in the advanced stages. The Minister for Health and the Minister for Education have been listening to the Irish Family Planning Association, an offshoot of the International Planned Parenthood Federation. The result: ever-more-widely-available contraception and proper sex education are, it seems, the solution to our rising teenage pregnancy and abortion rates. Again, they have bought into this in the face of evidence to the contrary. Ireland is a country in full reality-denial mode.

An infuriating aspect of the whole debate was the manner in which feminist and sundry other pro-choice groups, backed by government money, could walk down the halls in government buildings and state their case before various politicians. Meanwhile, pro-life lobbyists had to knock on doors very hard indeed to gain a hearing, but they were accused of being "intimadatory" anyway.

Another example: when the man at the centre of the "X Case" had his sentence reduced from 14 years to four in the immediate aftermath of the abortion debate, feminist groups stirred up public indignation. A few days later, the state-funded Council for the Status of Women demanded and were granted a meeting with the Minister for Justice, at which they insisted that sentencing policy be reviewed. Their request was granted.

What we have now in Ireland, thanks to the abortion information bill, is a piece of rank hypocrisy, "an Irish solution to an Irish problem." Abortion is illegal, but here's how you can go about getting one.

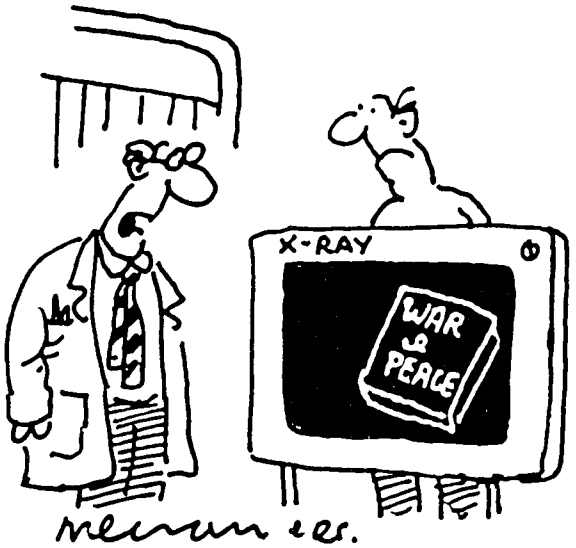
There are two ways to resolve this state of affairs. Rescind the abortion information bill (in fact President Mary Robinson has referred it to the Supreme Court to test its constitutionality), or legalise abortion in Ireland.

In the end, even if the bill is found to be unconstitutional, the second solution is the most likely, given the state of mind of our ruling class.

The next stop down the line is euthanasia. We have already begun to debate it. In my column I predicted that since it is now legal to provide Irish citizens with information on services which are illegal here, but legal overseas, doctors will soon have to provide patients with information on assisted-suicide services.

A few days later an evening newspaper carried a headline story reporting that the Dutch Embassy in Dublin has been receiving calls from Irish people enquiring about euthanasia services in Holland.

Ireland is entering the Brave New World at breakneck speed. Soon it will be legal to kill the very young, and the very old, and other such burdensome types, in the land of Saints and Scholars.



'You've got a novel in you.'

THE SPECTATOR 25 March 1995

In a Basin Clearly

George Mulcaire-Jones

Friday, 6:00 p.m., September 30th. Three deliveries and two hours of sleep in the past 36 hours. I run to escape the weariness of a solo obstetric practice.

Ascending out of town on a dirt road, the majesty of fall in Montana envelopes me. Ahead are groves of golden quaking aspen. In each direction are mountain ranges freshly dusted with snow. The sun streaks through the clouds, casting long shadows across the foothills.

I click my beeper off. Being alive is a damn sight better than the alternative.

Four hours ago, I received a panicked call from the hospital labor and delivery staff. A laboring patient had the sudden onset of fetal bradycardia. For 6 minutes the heart rate had plunged down. I arrived immediately and, with oxygen and a medication to relax the uterus, the fetus recovered nicely. We proceeded to a prompt Cesarean-section and out came a healthy, vigorous baby boy.

Would I have driven through two red lights if I had known the baby had Down's syndrome? What if the baby had spina bifida? Would I plunge a knife into the mother's uterus to save a child whose quality of life could be compromised?

What about the woman I saw yesterday with an elevated alphafetal protein? The ultrasound we did looked normal, yet she wants to keep her options open. She has scheduled an amniocentesis out-of-town for the following week. If the chromosomes are abnormal, then what?

Then what?—the question haunts me daily. Delivering babies seems to be the easy part now. With modern perinatal and neonatal care, we can usually negotiate the "traditional" problems of preterm labor, toxemia and placenta-related bleeding with favorable outcomes for the mother and baby.

It is running the prenatal diagnosis gauntlet that gets tricky, especially if you are pro-life. The available tests range from alphafetal protein and multiple-marker screening to chorionic villus sampling and amniocentesis. The obstetric literature is replete with the latest studies and indications for various tests. While an argument can be made for the usefulness of prenatal diagnosis for couples who would not consider abortion, the thrust of

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prenatal diagnosis lies elsewhere.[1] Seven out of ten women who have a fetus with a known chromosomal anomaly terminate their pregnancy with an elective abortion.[2] For the chromosomally abnormal fetus the bounty has been set:

> A gross estimate for detection of each case of fetal Down's syndrome in our program is about 100,000 dollars. It was estimated in 1981 that the average health, education and residential costs for an individual with Down's syndrome were 196,000 dollars. This did not include other costs such as loss of productivity of parents, counseling and social-work services, increased divorce rates and problems with siblings. [3]

A vegetable, a person? A human life or a lifelong burden? I explain to my patients that these tests pose not only medical questions, but philosophical and ethical questions as well. If the blood tests are abnormal, then what? If the amniocentesis shows Down's syndrome, then what? If I choose to have an abortion, then what?

No longer can a woman journey through pregnancy with an ethos of "Let it be." In modern obstetrical ethics, the examination of conscience is replaced by the examination of options. Morality is reduced to an exploration and exercise in personal autonomy. Will an ill-timed baby interfere with my career track? Can I have an abortion quietly and discreetly without my parents' knowledge? Am I willing to risk a chance my baby will be mentally handicapped? In the portfolio of options, the fetal heartbeat becomes increasingly distant.

We as physicians become the priests of the new morality. Our role is to be objective and non-directive, presenting the options in all their neutrality. To the woman with a positive pregnancy test, we are careful to ask "Is this a planned pregnancy?" and "Have you considered all your options?" Choose your words carefully—"developing embryo" instead of baby, "previable" instead of living; at all costs avoid talking about the "Big A" in any graphic detail.

We preach in numbers—tables of age-related chromosomal anomalies, risk-benefit ratios of procedures, the "high" and "low" probabilities that define what is human. To the wary patient, we must be sure to note the "false negative" rate of any procedure, the chance that our tests would detect a less-than-perfect baby.

The march of statistics is frequently bewildering to the patient. Knowledge and numbers don't always illuminate what is at the heart of the issue. As more than one patient has expressed to me: "Why all the fuss, Doctor, if I would never consider an abortion in the first place?"

Three miles into the run and I still think life is good. If I had Down's

syndrome, I could still breathe this air. Even with an extra chromosome, I could see the leaves quiver and smell the damp foliage.

Slowly I climb the last hill with the cascade of "then-whats" reaching a crescendo. As I look to the valley below and the sky above, I wonder "Then what happens to our souls?" What happens to the souls of the unborn and to the souls of us who turn the other way? In the fading light, where are they?

I am confused; the edges have frayed. The boundaries between life and death blur. The corridors once secure tremble beneath my feet.... I become the unborn, running this road out of town. Behind the gray-barked trees hide the abortionists, their poisoned arrows aimed at my imperfection.

The terrain is at once familiar and frightening. I too have touched the arrows. I've held the forceps and instruments—the cervix opening and the contents of the uterus pouring forth... in this life, there are no safe corridors.

Three days ago there was a clear heartbeat. Then a trickle of blood and stillness on the ultrasound screen. "A fetal demise, human reproduction is not perfect," I explained to the mother. She fixated on the ultrasound screen, her eyes filled with anguish, and cried "My baby is dead."

Driving from the hospital, the queasy feeling hits. I steel myself. The baby has died, the uterus needs to be emptied. I assure myself it is a task that I will do competently and compassionately.

The queasiness persists. In another city, a doctor drives to meet a woman whose womb tumbles with life. I know where he is going. I cannot stop him. The bounty is collected, the slayer poised, the arrows drawn in deadly, determined hands.

Gone is the usual banter of the operating room. In filtered quiet, I take the instruments deliberately—a number 12 dilator, tissue forceps, the vacuum apparatus, a sharp curette. Carefully I empty the uterus, directing the blood and fluid and flesh into a steel basin.

I've delivered death. I identify the parts submerged in blood: a forearm, a leg, part of the thorax attached to the vertebral column. A hand floats by palm up: perfect, fine, fingers spread like a star.

In the basin lies neither rhetoric or statistic. Abortion shakes me in the guts. Choice? Compassion? What words can sanitize the bits and pieces of a human staring at you? Do the sum of the parts make a whole? This baby, ripped apart, torn asunder—what we cannot recognize in life spills out in death.

Death, our own death. In the basin, we see our fragile reflection. We who've traversed this passage. This is not alien tissue in a strange land. We know our own.

Our own, despised and rejected, unknown and unwanted. Who shall name us? All that we are and shall be spilled into this steel cup.

I raise it off the table, the edges shimmer red and silver. Methodically, I examine the clots and fragments, my nerves beginning to betray me. I have a job to do. Standard abortion textbooks admonish the operator to find and identify all fetal parts.

Somewhere lies the missing calvarium . . . what a strange word. I remember my brothers hiding the last piece of a jigsaw puzzle, hoping to complete the picture.

A thousand points of death, a disassembled human being. The blood-red darkness climbing to the sky.

As I run, I pray . . . . Can we be cleansed?

NOTES

1. S. Clark, G. Devore, "Prenatal Diagnosis for Couples Who Would Not Consider Abortion," *Obstetrics and Gynecology 1989*, vol. 73, no. 6, pp. 1035-1037.
2. J. Haddow, G. Palomaki, *et al.*, "Prenatal Screening for Down's Syndrome with Use of Maternal Serum Markers," *New England Journal of Medicine*, 1992, no. 327, pp. 588-93.
3. O. Philips, S. Elias, *et al.*, "Maternal Serum Screening for Fetal Down Syndrome in Women Less Than 35 Years of Age Using Alpha-Fetoprotein, HCG, and Unconjugated Estriol: A Prospective 2-Year Study," *Obstetrics and Gynecology*, 1992, vol. 80, no. 3, pp. 353-8.

Why My Brother Won

Maria McFadden

Last December 30, a 22-year-old hair-styling student from New Hampshire, John Salvi, entered an abortion clinic in Brookline, Massachusetts and started shooting. He killed Shannon Lowney, a 25-year-old receptionist, and wounded three other people. He then proceeded to another clinic a few blocks away, where he shot and killed 38-year-old receptionist Leeanne Nichols.

The following morning, I had CNN on the hotel TV as I dressed for a funeral. Robert, my older 34-year-old brother, had succumbed to cancer 3 days earlier. He had been a pro-life lobbyist in Washington. As my husband and I got ready, steeling ourselves for the difficult day ahead, I listened to Shannon Lowney's fiancé tearfully mourning her untimely death, and angrily defending her pro-choice employment. It was a sad enough day, made sadder by another blow to the pro-life movement and the thought of two more families, that holiday season, plunged into grief.

It was very hard making arrangements the day Robert died. A tear-soaked group of us bravely processed to the church, to speak to the priest about the funeral; then to the funeral home, and finally to the cemetery. Though his death was expected, the actual event left us shocked and numb. We were amazed that we could manage to function . . . but we had to, of course. And here it was, three days later, and two families who had probably been planning New Year's Eve festivities were suddenly faced with the unbelievable necessity of making plans to bury their loved ones. They, unlike my family, had had no time to prepare, no time to say goodbye. And now they have a reason to hate the pro-life movement, blaming it for Salvi's act of terror.

It seems ironic to me that the Brookline killings came so soon after Robert's death, because one thing that Robert was quite concerned about in his last year of life was the escalation of pro-life violence. Of course, contrary to what the pro-choice media would have us believe, Salvi, like Paul Hill and Michael Griffin before him, acted alone. Salvi in particular seems, by all accounts, to be clearly unhinged; though he is (for shame!) a "scripture-quoting" Roman Catholic, a crazy, rambling letter he wrote in prison shows a paranoid and psychotic individual. His motivations were

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less religious than delusional. Whereas the majority of those involved in the anti-abortion movement are sane, peaceful and law-abiding citizens. However, acts of violence have been on the rise, and there is a faction in the movement that promotes "justifiable homicide" for abortionists and their accomplices, and uses religion as the justification.

Robert and I used to commiserate with each other about this: how the violence allowed the media to paint us all as extremists, how frustrating it was to see the harm that the Pensacola killings did to the movement. I remember one day last August, a few weeks after the Hill shootings. I was sitting at home waiting for my then-overdue baby, and Robert was at home recovering from his latest round of chemotherapy. Both of us had seen, on separate talk-shows, a priest arguing for justifiable homicide. As Roman Catholics, we were appalled to see a man in a Roman collar espousing such views.

The priest making the rounds of day-time talk TV was one David Trosch, from Mobile, Alabama. He had first gained notoriety when he tried to publish an ad in the Mobile *Register;* it showed a man pointing a pistol at a doctor, who was holding a knife over a pregnant woman. The headline was "Justifiable Homicide?" The paper declined the ad but did a story on Trosch, who was then warned by his superior, Archbishop Oscar Lipscomb, to be quiet. When Trosch refused, he was eventually stripped of his parish and salary, and forbidden to say Mass with anyone present. But that didn't stop him from going nation-wide with his "message," in effect inviting the viewing public to think that there might be something in the pro-choicers' accusations that the Catholic Church is encouraging violence.

As Robert and I agreed, it is obvious why a man like Trosch would get all the media attention, rather than the thousands of pro-lifers who work in the trenches, day after day, away from the public eye—controversy makes better TV. But, as we also agreed, there *is* something dangerous going on: more and more, the "fringe elements" of the movement are taking the law into their own hands.

Robert saw the trend toward violence and even toward compromise as a symptom of frustration with not winning a war in which many of the soldiers were sure that God was on their side. Frustration and loss of patience were leading to a willingness to break the rules in order to gain the desired end. Not that there wasn't an understandable reason to feel thwarted, with all the setbacks the cause had suffered, but Robert, as a believing Christian, and an exceedingly gentle and generous man, was saddened to see people turning to harsh tactics.

Last spring, Robert wrote down some of his thoughts about this, intend-

ing to re-work them into an article later. That spring was a time of hope for him: he had endured a bone-marrow transplant, and it had been declared successful. We thought his cancer was gone. (This was in May; unfortunately, in late June a CAT scan showed the cancer back, and spreading.) This was also before the second incident of Pensacola shootings.

Robert was worried that there would be more violence, and he was right. He wrote about the danger of a believing person, in his case Christian, who is so intent on doing God's work that he forgets that God is still in charge, and so are His commandments. The extreme cases of this thinking would be "pro-life murderers"—people who kill an abortionist to save babies, but deny the victim his own life, and even time for repentance and amendment. Other cases of this thinking in our own movement would be, Robert thought, people who lie to women to get them into anti-abortion "counseling," who shout "murderer" at women going into abortion clinics, and the publishing of "wanted posters" and other tactics to harrass abortion doctors.

As for Robert, his fight was also "pro-life." He wanted to live, and he hoped God wanted that too, but he didn't presume that was so. His wife Mary told me that all their prayers for his cure ended with Robert saying "but Your will be done." All those around Robert were amazed at his optimism, cheer, and his determination to fight for life, even in the face of worsening diagnoses that meant, barring a miracle, he would lose. As I reread his words of last May, exhorting his fellow pro-lifers to fight fair, I realized that many of them could also apply to Robert's personal battle. Fighting the "good fight" for him meant keeping going, day after day, while facing pain, sickness, worry and fear—without complaining. He never got angry or bitter with God, he never lost enthusiasm for his work, and he never stopped caring about other people's problems. He didn't use his illness as a justification for any type of selfishness or self-service. He would go into the office as much as he could, even a day after chemo, and go to meetings, even when he was feeling awfully self-conscious about his falling-out hair. When he could no longer make it into the office he worked at home from his computer. All the time he hoped he would make it, for his wife's sake and for ours.

In memory of my brother, and in the light of the Brookline shootings and the debate over pro-life extremism that has followed, I would like to share excerpts from Robert's writings on fighting the good fight.

* * * * *

May 1994

It is never correct to say that God is on our side. It is in fact quite presumptuous. He is not here to do our bidding, after all. All we can actually hope for is that through our own choices we will put ourselves on God's side of things. Of course where we mess up is that we desire it to be the other way around, and then in our minds make it so. We bow to the temptation to have God on our team, with ourselves as coach.

It is this view of things that leads a person, dedicated to defending human life, into cold-bloodedly murdering a human life. When Dr. David Gunn was murdered outside his Pensacola, Florida, clinic by Michael Griffin, one of the first sober realizations for some was that, although it had taken many years, it had finally happened. The passions engendered by this debate of human life and death had finally, tragically, overtaken one of us. But what we then discovered shocked us: the pro-life murderer was not pointing to passion as the cause of his crime but was in fact denying a crime had occurred at all. He believed himself morally justified in what he had done because Gunn was an abortionist. We were further shocked to hear voices in the pro-life movement agreeing with him. Others, including a Roman Catholic priest, had the moral clarity to condemn his actions, but added the mitigating statement that his actions would in the future save babies from Dr. Gunn's hands, thus indirectly justifying the deed anyway.

It is hard for most of us to envision God applauding this person's action, clapping him on the back and exclaiming "Good shot!" But it is not difficult to imagine a teammate doing just that. And what a teammate! "Lord knows, if we are to win this thing we need God on our side," says the pro-lifer, and away he goes to "off" an abortionist. With "God on our side" there are many things we can do, from bombing clinics to destroying clinic equipment to screaming "murderer" at a pregnant woman entering the abortuary. But the conflict surrounding abortion is not a game between teams but rather a fight between the elemental forces of good and evil. That is not a battle mere humans are meant to win or lose. The choice presented to us in this fundamental struggle is to fight either against Light, or Darkness, and to do so until we pass on from this existence. Far greater forces than us will eventually win, and lose. And the fact that we have already been told the outcome, that Good will triumph over Evil, does not give us the right or the excuse to attempt to hurry that outcome along in our own time, by our own devices. The choice which is presented to us, in this abortion battle, is not ultimately about which side we are on

but whether we desire to lose our soul, or save it.

* * * * *

On a filthy street in a decrepit part of town in a city called Calcutta a small woman hovers over a dying man. She does not ask what this man had done with his life, nor does she care what his politics are. If he were Adolf Hitler or Josef Stalin I do not think she would hesitate to help him. She rescues child molester and child protector alike. She does it because it is the right thing to do, the moral thing, the Godly thing, if you will.

What Mother Teresa does not do is lead a crusade whose goal is to end poverty in the world. We do not see her on Phil Donahue exhorting people to contribute to her organization which will end poverty and hunger by the year 2000. She does not do this because she knows a simple truth, that the poor will always be with us, and that we are not meant to create a Heaven on earth. Besides, God has sent her plenty that comes right to her doorstep. She knows that if everyone helped a few people around them, we might actually come close to performing the impossible. Still, such ruminations are not for her, as she and her helpers move from dying body to dying body.

. . . It is our pride that whispers to us that abortion is such a horrible thing that we *must end it. It is pride that further whispers to us that we* can *end it, and that we have the power. We are fooled in some cases because we struggle to eschew obvious self-pride which is easily seen and in fact* pride *ourselves on our efforts to practice humility. But as soon as we listen to the whisperings, as soon as we believe that* we *can win this frightful war, there is almost nothing that some of us won't do, to make victory possible (including shooting a human being down in broad daylight) . . . Once we allow pride to have its way with us by actually thinking that we can (and even must) win this struggle it is no longer a question of whether we will compromise but rather how much. . . . The ultimate responsibility for the world rests on shoulders far bigger than ours. This does not release us from responsibility but instead focuses our attention on our individual responsibility to do what is right, what is moral. When we suffer losses in the political fight over abortion we can shrug them off because a) we know we will ultimately win (although not necessarily in our lifetimes), and b) we're aren't expecting to win anyway. It is right to fight abortion, not because you can win, but because of what abortion is.*

* * * * *

A Wahington Post *story dated April 8 tells of an old woman being called at 3 o'clock in the morning by a man informing her that her son, a 47-year-old abortionist, has been killed in a car accident. The man identifies himself as a state trooper. The phone call is a lie, and Dr. Frank Snydle comes home several hours later to find his mother hysterical. His mother is 80 years old, and has a heart condition. Her crime? Her son performs abortions. His car windows have been smashed, and his home and office picketed. The* Post *reports that "Wanted" posters featuring a $1,000 reward for information leading to his arrest or the revocation of his medical license have been circulated widely... The posters also list his mother's address and phone number and the license plate for two ex-girlfriend's cars.*

... Little is said [by pro-lifers] about such events because of the desire to present to the press a unified front, as much as possible. Also there is understandably a great reluctance to chastise fellow pro-lifers, not least because with some groups such criticism can be answered with outraged cries of treason. But partly because there isn't swift condemnation from within the ranks when such acts are perpetrated, these abuses have been increasing. Dr. Gunn's murder, rather than being the culmination of such acts, may be only a new beginning.

... It will be difficult for many to accept that their best-intended efforts to rid the world of a tragic wrong can be in themselves wrong. It is so easy for those of us who believe we are on the right side to look the other way whenever the fight against abortion seems to call for questionable methods. Furthermore, the willing performance of immoral acts will more often than not produce consequences undesired by the perpetrators. Terror did not ultimately convince the world of Hitler's rightness, nor did it work for the Soviets. But Jesus Christ continues to win converts 2,000 years after His death, with a message of peace, love and compassion. The pro-lifer who uses terror tactics, such as picketing doctors' homes or calling in anonymous death threats may succeed in stopping that doctor from performing abortions, but he will not have converted that doctor's heart. Certain abortionists (and a few of their clients) have reported that the violent behavior of some of the pro-lifers has increased their resolve to defend abortion. In short, as all dictators have discovered, if you win by terror your victory lasts only as long as you have the energy to maintain the terror. That is not how we should be trying to win this struggle.

A woman who is looking for help and understanding is certainly not going to appreciate the fact that the people she has turned to have lied to her. Perhaps some women will accept the argument that the abortion situ-

ation makes such lying necessary. But many won't. They are looking for people to trust and that trust has been violated. Some of these women will leave, and their babies will be lost. And word will spread, and other women won't even try, believing that the pro-lifers are as much liars as the abortionists.

Blowing up clinics, or fire-bombing them, or even breaking in and destroying equipment, may seem to some acceptable guerilla tactics to win this war. But what gives us the right to potentially put people in danger to further our cause? How does the midnight bomber really know the clinic is empty, or that the explosion won't hurt someone a block away? The same holds true for the arsonist—what if the whole block is destroyed and people are killed? In destroying equipment one runs the risk that an item may not be thoroughly damaged, and may be used on a woman, injuring or killing her. Even if these events aren't likely, who are we to take such risks? Besides, even if these actions are successful in stopping one clinic from performing abortions, you have not produced true converts, only resentful people reluctantly complying, for now, with what is demanded of them but vowing to get even someday. And another clinic across town or across the country continues its work.

Public perception is a crucial element in any struggle in the public square. It is so much harder to prove your position if the populace is not sympathetic to your side. Currently, to the dismay of many, pro-lifers are being perceived as angry, violent radicals who will hurt you if you don't agree with them. This perception is unfair when applied to the anti-abortion movement in toto *but it accurately defines an increasing minority.*

. . . The answer to all this is a Chestertonian paradox. In order to win this struggle we must avoid trying to win it. We must do what we do against abortion not because this or that action will secure us a victory but because it is right to perform that action. We can fight endlessly for good, moral legislation to save unborn children, but with the willingness to lose a fight rather than sacrificing principles to win. We can try to remember Christian charity and compassion for those among us who are risking their chances of eternal happiness by fighting against God. Instead of hating these people, and trying to hurt or terrify them, we should be praying for them, and treating them with the basic civility Christians used to be known for. The children they are complicit in killing go to God. The real victims are those people who, either by their own volition or the persuasion of another are through their actions repeatedly driving a knife through their own souls. We must continue to educate, to provide the calm voice of reason and logic to counter the often hysterical rantings of the

other side.

We must try to "play this game" as if we were on God's team, trying to follow His coaching, and not as if we were coaching God.

* * * * *

If I were coaching God, Robert would have won his fight with cancer, and be here to write this himself. I and many others certainly lobbied hard for that. But the worldly failure, for us believers, is really Robert's gain, because he is with God.

And, whether you are a religious person or not, Robert's thoughts may help to make sense of setbacks in a struggle for the good. When our attempts to educate the world about abortion seem to fail, we have to remember that lives are saved one at a time, and that, successful or not, we may not abandon the moral path. Hatred and violence only hurt our cause and harden people's hearts.

Robert's way of hope and faithful perseverance is the only way to truly win.

Rigging the Human Market

Alasdair Palmer

Alasdair Palmer investigates the wilder fringes of the transplant business, and meets a surgeon with a radical solution to the shortage of donors in Britain.

Last week, Mr. Stephen Hyett left hospital in Cambridge with a new kidney, liver, stomach, pancreas, duodenum and small bowel. He was lucky that the operation was such a success. He was even luckier that the appropriate organs were available. For many who need them, they are not—at least not through the normal channels. But there are others.

Consider this request, sent to *The Spectator* by Mr. Chandrapandey, an Indian gentleman from Lucknow: "With due regards I beg to state that I want to advertise to sell my fresh kidney at $150,000. I will pay you fifteen per cent of the receiving amount. I have chosen your magazine for its rich readers."

Mr. Chandrapandey was disappointed in his hopes of selling his kidney in this country for $150,000, and not just because he was wrong in his charming belief that "for the British, $150,000 is not much." Aware that payment, or facilitating payment, for human organs is a crime punishable by imprisonment in the United Kingdom, *The Spectator*'s editor took the safe way out. He refused to run the advertisement.

Mr. Chandrapandey was therefore forced back to the local market in human organs. And in India that market is flourishing. It has brought the price of kidneys down dramatically. In Bombay they can be purchased for considerably less than $150,000. Between £8,000 and £10,000 will buy you a new kidney, *including* the operation required to transplant it into your body.

For those waiting on the long and continually growing list for kidney transplants in Britain, the option of an instant operation can be tempting. Anyone on the list knows that here demand exceeds supply by around four to one. Death on the NHS waiting-list is a regular occurrence. Whether you live or die can come down to a question of luck—and whether you can survive years undergoing the considerable pain and boredom of life on dialysis. Small wonder, then, that some find it impossible to resist the

Alasdair Palmer is the home affairs editor of *The Spectator*, in which this article first appeared (July 2, 1994). It is reprinted with permission;

quick way out: a trip to Bombay to take advantage of the bargain prices and purchase a new kidney there.

It is a practice most common in the British Asian community, where there can be strong religious prohibitions against the use of kidneys from corpses. Dr. Jonathan Odum, of New Cross Hospital in Wolverhampton, explained to me that a leading Wolverhampton Sikh started the trend amongst Wolverhampton Asians. The success of his Bombay operation encouraged others. "We can't stop them going, however much we deplore the trade," Dr. Odum told me. "And we cannot refuse to treat them when they get back having had the transplant, when they need to continue courses of immuno-suppressant drugs or whatever." Dr. Odum was worried that he and his colleagues might be seen to be accessories to a crime by treating those who'd purchased kidneys in India. In fact, it turns out that legally they'd be more at risk if they refused treatment. "But it is a dilemma. In effect, we're rewarding them for what they do," he said gloomily.

The practice of purchasing kidneys—or any human organ—was outlawed in this country by the Human Tissue Act. That act was passed in haste in 1990, in the wake of a kidneys-for-cash scandal in London: Dr. Raymond Crockett from the Humana Hospital arranged for Turks to come to London and have their kidneys out in return for a small fee. Dr. Crockett lost his job and his license, and the Human Tissue Act zipped through the Houses of Parliament in record time. What generated the hysteria, apart from the general revulsion against the traffic in human flesh, was that at least one of the Turks did not seem to appreciate that he was going into hospital to have his kidney removed.

The Humana Hospital scandal was, however, very tame stuff by comparison with what goes on routinely in India. Kidneys bought there come steeped in human misery, as Dr. Odum reminds anyone who thinks of nipping off for a transplant. One Indian woman, for example, was forced by her brutish husband to give up one of her kidneys. She was given an alarm clock and a battery for her transistor radio for her pains. He received the money, which he proceeded to gamble away almost instantly. Anyone who investigates kidney transplantation in India comes back with dozens of stories like that. They don't move the blindly self-interested, but there are drawbacks to purchasing a kidney even for them. A study of 130 patients from the United Arab Emirates and Oman who had purchased new kidneys in India showed that four tested positive after the transplant for HIV (having tested negative before it); three were infected with hepatitis.

"But the trouble is," sighs Dr. Odum, "none of the patients who has

come back to this country has been infected. It makes it much more difficult to persuade people of the risks they are running." Those risks are nonetheless very real. Blood is still not routinely tested for infections in many Indian hospitals, leaving aside the dubious qualifications of many of the surgeons.

The fact that people are willing to make the trip to Bombay and risk infection with the AIDS virus indicates how desperate the shortage of organs for transplantation has become in the United Kingdom. It is not just a question of kidneys. There aren't enough hearts, lungs or livers for those who need transplants either. All of which shows just how lucky Mr. Stephen Hyett is. He was lucky that the operation worked. But he was even luckier that someone with his tissue type, and with all the relevant organs in good shape, died in the appropriate way and at the appropriate moment, with relatives who were prepared to authorise doctors to remove his insides. Most people who need livers, hearts and lungs, and many who need kidneys, are not so fortunate. They die before suitable replacements can be found.

The basic problem, as any transplant surgeon will tell you, is not enough corpses. Corpses are the only source for lungs, hearts and livers, and for all but 8 per cent of kidneys. Road traffic accidents are one of the principal sources of corpses whose organs can be re-used: the victims are normally young and healthy, and die from head injuries which leave their organs intact. Legislation introducing compulsory seat-belts probably has done more to contribute to the organ shortage than anything else: countries like Austria and Belgium, which transplant kidneys at a rate more than twice that of the United Kingdom, also have more than twice as many fatal road accidents.

This is one NHS shortage which cannot be blamed on Mrs. Bottomley. No amount of increased government spending is going to eliminate the waiting-list for transplantable organs. Increasing road accidents would help, but even the most enthusiastic "cutters" (apparently a term of endearment for transplant surgeons) will admit that it is not a feasible alternative. Changing the law to allow the use of organs unless an individual has specifically drawn up a document forbidding it whilst alive is one possibility, but not one that surgeons favour. Ignoring relatives' wishes is a recipe for a public relations disaster, even supposing there were no independent moral objections against changing the system of organ donation from a voluntary to an essentially coercive one.

It's anyway unlikely that a switch of that kind would increase the supply significantly. At present, around 20 per cent of relatives refuse permission for the removal of organs from suitable victims. The majority of those are thought to be hard-core opponents of organ removal, who would stay that

way however the law was changed.

Everyone wants the supply of transplantable organs increased. No one, however, has any ideas which combine solving the shortage with being ethically acceptable. There are various technical suggestions relating to ventilating "brain dead" bodies for longer in intensive-care units, and for improvements in the way that transplantable organs are co-ordinated with transplant surgeons. Those proposals might make a difference at the margins, but they aren't going to solve the problem. Michael Bewick, renal transplant surgeon at Dulwich Hospital, points to some of the more radical alternatives employed abroad. "The Chinese use the organs of executed criminals," he explained to me. "It was the transplant surgeons who persuaded the Chinese authorities not to shoot criminals in the heart, but in the head. That way, the heart doesn't go to waste. I'm not personally in favour of capital punishment, but if you do have it, why let all those good organs simply be destroyed?"

Mr. Bewick points out that reusing their organs is a genuinely practical way in which a criminal can pay his debt to society. He mentioned the use of the guillotine in France to execute a murderer in 1958. "Two leading French surgeons played poker for that man's kidneys. It was the pioneering days of renal transplants. You might not like the way they decided who would get them, but at least those organs weren't wasted."

Apart from corpses, the other source of kidneys is donation by live adults. Mr. Bewick has some radical ideas here as well. Evolution has oversupplied humans with kidneys. We all have two, but each of us only needs one. Having the operation to remove one need not cause any health problems at all. "There are thousands of usable kidneys out there, if only people could be persuaded to give them up," he enthused. Money is the most effective incentive, and Mr. Bewick suggests offering a financial reward for anyone willing to donate his kidney. He knows it can work. He has personal experience of it. He was the surgeon involved with Dr. Crockett in the notorious kidneys-for-cash case in 1989.

Mr. Bewick has always denied that in the Crockett case he knew that the men he operated on were being paid for their pains, but he was none the less censured by the General Medical Council for failing to find out, and banned from private practice for a year. But he has never been opposed to the principle of paying people in order to induce them to come forward and donate. "Why should anyone be? At the moment, when a kidney is transplanted, the surgeon gets paid, the theatre staff get paid, the nurses get paid, and the hospital gets paid. The only person who doesn't get paid is the poor donor. But he's the one making the sacrifice. Is that a fair and

humane way to treat him?"

Mr. Bewick's view, though shared by some professors of medical ethics, has made him a pariah amongst transplant surgeons. Whilst his colleagues recognise his great contribution to the field, they are horrified by his ethics, or at least by his public avowal of them. The received wisdom, accepted by politicians of all persuasions, has been trenchantly expressed by Sir John Banham, Professor of Transplant Surgery at Oxford: selling organs is incompatible with human dignity. Mr. Bewick, interestingly, takes the opposite view: not buying them is incompatible with it. "The ban doesn't stop trading," he told me. "It merely drives it underground and makes exploitation more not less likely. People say it would mean the rich would exploit the poor. So what's new? That's capitalism! Or any other economic system, for that matter. We need government to control and organise payment, which would increase the supply and stop the worst of the exploitation."

Mr. Bewick is convinced that the Human Tissue Act was not properly thought through. Repealing it, and establishing a controlled market in human organs, would, he argues, overcome the terrible shortages. He may be right that the absolute ban on payment has more sentimentality than sense behind it, but he has a wildly over-optimistic view of the ability of government to police an organ market successfully. "Necessity makes a bad bargain," wrote Sir Francis Bacon.

No one is ever going to sell—as opposed to give—his kidney except through economic necessity. The fate of most of Bombay's organ donors is not an encouraging precedent. All the organ markets which exist seem to be hideously exploitative, if not straightforwardly brutal, and there is no particular reason to think that legalising it would magically enable governments to diminish the force, fraud, bullying and deception currently characteristic of the trade.

And legalisation might have exactly the opposite effect. Making it acceptable for hospitals to purchase organs would immediately encourage the thugs already in the market to step up their work-rate. Criminal gangs are already known to have kidnapped children for their organs in Russia and South America. Dr. Jean-Claude Alt, one of the main campaigners against the trade, says brokers are regular visitors at one particular children's home in St. Petersburg. They arrive saying they'll adopt any child, with any disability, no matter how severe—providing the child has no heart trouble. "There's only one conclusion you can draw from that," Dr. Alt adds ominously. "They want to transplant the child's heart."

If he is wrong about the practicality of a morally acceptable organ market,

Mr. Bewick is certainly correct that increasing the number of live donors is critical to increasing the supply of kidneys in the United Kingdom. The number of suitable corpses is not going to increase; if anything, it will diminish in the future, as road safety continues to improve. The only resource left is living donors. If buying and selling is unacceptable, the ever-resourceful Mr. Bewick has radical ideas on new ways to increase their number without money changing hands. "In Malaysia," he explains, "prisoners can negotiate a reduction of their sentence if they agree to donate one of their kidneys. It may sound harsh, but actually everyone benefits."

Other kidney surgeons, however, are utterly opposed to that idea. "Of course we need more live donors," Mr. Christopher Rudge, a London surgeon told me, "but they must be genuine donors, not people coerced into the operation. The worst thing we could do for voluntary donation is to associate with criminal bargains." Like all other renal surgeons (including Mr. Bewick), Mr. Rudge is required by law to go to enormous lengths to ensure that families of individuals who need a new kidney do not feel bullied or pressured into giving. Kidney surgeons become expert at detecting family coercion. "It can happen in all kinds of ways," says Mr. Rudge. "If we identify it, we have to cancel the operation."

A genetically unrelated donor—a husband, for example, wishing to donate to a wife—can only give up his kidney after the case has been carefully vetted by a government committee, a bureaucratic process which can take anything up to two months.

The operation itself is not without risks. The surgeon and anaesthetist who remove your kidney have about one chance in 2,500 of killing you. That may be what puts people off—but there is no reason why it should. In Norway, for instance, nearly half of transplanted kidneys are donated from living relatives, which is over five times the rate of live organ donation in the United Kingdom.

The low figure is partly a testament to the reluctance of many transplant units to inform family members that donation is a solution, for fear of being seen to pressure reluctant brothers, sisters, parents or children into an operation they don't want.

A campaign to increase live donors might help to reduce the waiting-lists for kidneys, but without the introduction of financial incentives it won't eliminate them; and it cannot touch the shortage of other organs. The waiting-lists, therefore, are here to stay. And so are the waiting-list deaths.

The shortage leaves surgeons with the decision of who to treat. "You can have a kidney which will fit either a man in his forties with a job and three children, or a retired single woman in her sixties without dependents.

Strict medical criteria won't always make the choice for you," explains Mr. Rudge. "Deciding between them is a nightmare. It has got more difficult since the principles which formerly dictated distribution were abandoned." It used to be the case, for instance, that younger patients automatically had priority over older ones. That has changed over the last ten years. Why? "The surgeons themselves have got older," suggested Mr. Rudge. "It may make us not quite so keen on an inflexible age cut-off."

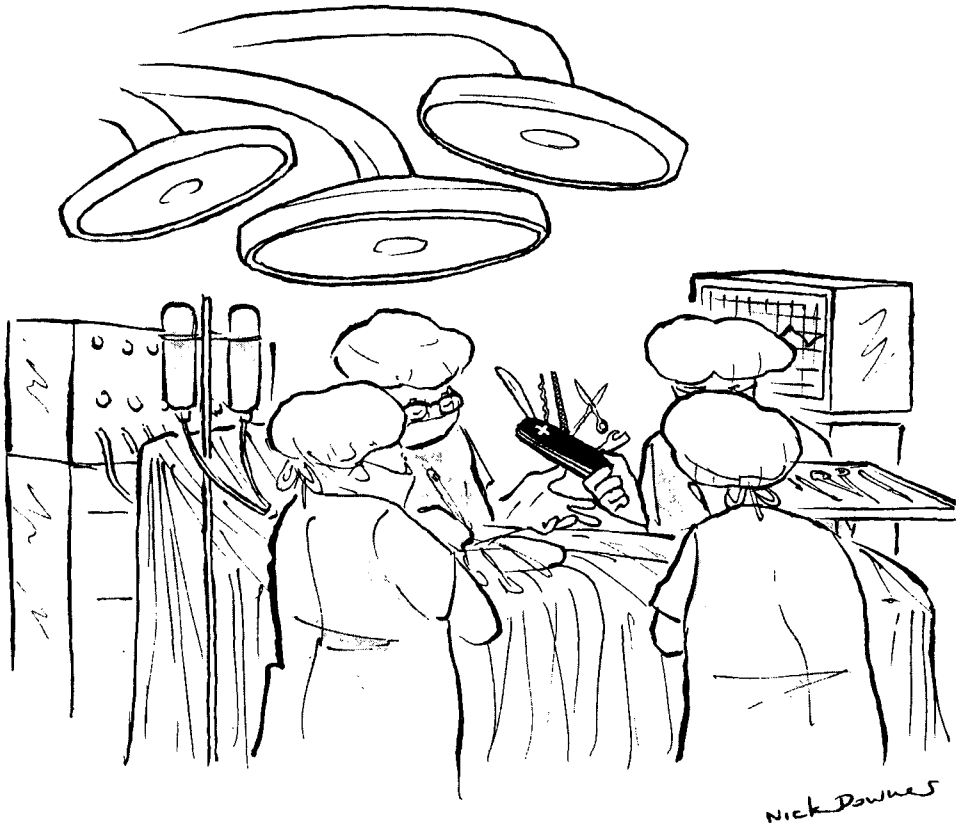
There are no official guidelines about how doctors should decide who shall live and who shall die, granted the suitability of a given organ for more than one patient. A nationally organised institution, the United Kingdom Transplant Association, acts efficiently as a clearing house for organs, helping to ensure that all that become available are effectively used. But surgeons have the final say on what they transplant to whom. "There isn't always an objective way of making the decision," says Mr. Robert Sells, who runs the renal unit in Liverpool. In the last analysis, he says, common sense is the best and only guide. But Mr. Sells, like every other transplant surgeon, is unhappy with a situation in which it is not always possible to demonstrate clearly that scarce organs have been allocated fairly, or to justify decisions to those who lose from them.

The mystery surrounding how those decisions are made encourages the suspicion that it all comes down to knowing the right people. The father of a friend of mine needed a heart transplant recently. The heart surgeon's first question, after deciding that the operation was necessary, was: "You don't happen to know anyone on a medical committee, do you? . . . No? Pity." The man died before a suitable heart could be found.

Surgeons reject absolutely that there is any preferential treatment available for anyone, no matter how well connected in the medical profession—although if there wasn't, surgeons would be the first group in human history not to look after their own. "No, you don't understand," Mr. John Darke, a heart surgeon in Newcastle, told me. "Transplant organs are very carefully controlled. It's a very small community. We'd know immediately if something unethical happened." Perhaps. But the impossibility of explaining exactly how organs are allocated means that stories of that kind flourish. No one wants to codify how the decisions are made, for the simple reason that the most basic element in the relationship between doctor and patient—trust—will be destroyed if patients come to know that the doctors treating them have already mentally written them off as prospective recipients. The reaction to the doctors in Manchester who publicly announced last year that they would not perform coronary bypass

surgery on heavy smokers has demonstrated that.

It is precisely the conviction that they won't be treated if they wait on the list which leads people to look to the black market in organs. As waiting-lists increase, the demand for black-market organs is going to go up. And so long as it happens outside the United Kingdom, there is nothing anyone here can do about it. Mr. Chandrapandey failed to advertise his kidney in *The Spectator*. But it has probably been transplanted into a British citizen by now.



THE SPECTATOR 19 November 1994

What Abortion Is Doing to Britain

Anthony Fisher

From the beginning, Christians opposed abortion.

However they differed over embryology and sanctions, they were convinced that all abortions and infanticide were wrong. This marked them out from many of their contemporaries. This was probably behind the New Testament anathemas against sorcerers, for abortifacients were one of the principal poisons they provided. Within a century even clearer denunciations came forth in the *Didache*, the *Epistle of Barnabas*, and thereafter from the pens of Tertullian, Clement of Alexandria, Basil, Ambrose, Jerome and Augustine. This attitude continued throughout the middle ages and beyond the Reformation: Luther and Calvin were every bit as opposed to abortion as their Catholic contemporaries. And in modern times the popes and bishops have been unequivocal: abortion—to quote Vatican II—is an abominable crime.

Where did all this come from? Partly from Judaism. The God of the Bible is a living God who communicates his life to all living creatures, above all to the pinnacle of his creation, human beings. Human beings are accorded great dignity, created uniquely as God's image and likeness, as little less than gods, intimately known by him, joined to God as in a marriage covenant, destined and oriented to him as their ultimate goal. In the Scriptural view of things, life is a trust given into our stewardship by God; we are called to choose life not death, and the ways of life not of death; any killing demands justification and the taking of innocent human life is always contrary to God's law and to that trust. No one should assume the role of the author of life and death.

This so-called "sanctity of life" principle had special application to the child of the womb. God in his providence creates human beings with a vocation and a destiny even in the womb; he treasures all children and gives them as a blessing to their parents. He deplores the deaths of even the youngest. Christian faith added a radical new dimension to this. For God had taken flesh himself as a human embryo in the womb of Mary, was heralded while still an embryo by his foetal cousin, John, and developed from unborn child to infant, adolescent and adult. The Incarnation

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and Redemption further dignified all humanity and called us all to become "children of God."

This is not, of course, simply a matter of quirky religious taboos or moral dogmatics sent by express post from the Almighty to the Vatican. In common with people of other religions and none, the Christian tradition teaches that human beings matter, they matter equally, and they matter very much. The source of this dignity is complex and can be couched in religious terms, secular philosophical terms, the political rhetoric of human rights, in poetry, in song. Shakespeare in *Hamlet* put it in these terms: "What a piece of work is man, how noble in reason, how infinite in faculties, in form and moving how express and admirable, in action how like an angel, in apprehension how like a god: the beauty of the world, the paragon of animals." As this last phrase notes, human beings are animals, organisms, living things.

So life, bodily, organic life, is a basic good for us, and it is a good irreducible to anything else like pleasure or consciousness or social usefulness. It is participation in that good of bodily life that makes much of what we do intelligible. There is not the space here to give a fuller account of how and why we regard life as a good, a sufficient reason for choices and actions, something we all share in common and part of our common good. Suffice it here to say that a very good case can be made out for the notion that life is a good *in itself*, and one does not have to give further reasons for promoting life and avoiding death.

One can construct a philosophical case, without Christian revelation, for the view that human lives are of such intrinsic importance that no choice intentionally to bring about an innocent person's death can be right. This sanctity of life principle has been much referred to in legal cases and earlier this year in the House of Lords' report on euthanasia. It is deeply embedded in law and ethics throughout the world, included in international human rights documents, and basic to our common morality. It has also informed medical ethics since at least as far back as Hippocrates.

The precept against killing the innocent is basic to morality, to community, and to civilisation. Its observance is an essential part of how we live justly and charitably. Abortion is demonstrably a case of killing. If the test of a civilised society is how it treats the most vulnerable—the old and the sick, the young and ignorant, the poor and handicapped, the homeless and despised, the dispossessed and powerless—then the death of these little ones convicts Britain of being not so much a post-industrial society as a post-civilised society.

But it does not end there. Britain's experience of abortion shows that

killing is like throwing a pebble in a pond. There is an immediate and obvious splash: the death of an unborn child—relief for the mother. But there are ripples that go out in all directions. Try as we may, morality can never be privatised: our choices inevitably affect others. Here I want to explore some of these ripples of the abortion splash.

Britain's abortion rate is high. Historically, it is without precedent here. It is not as high as some comparable countries (e.g., USA, Australia, Italy), but high enough. At an official 180,000 per year, every three years we abort the same number of people as the total of British casualties in the Second World War. There has been a dramatic acceleration of the abortion rate since the passage of the 1967 Abortion Act, giving lie to the notion that there is a certain definite pool of women who will have abortions whether they are legal or not, and that laws on abortion or availability of abortion are irrelevant to the demand. In fact it is not clear that demand for abortion is at least partly supply-driven. In the next generation we are likely to see the introduction of a range of contragestive and abortifacient drugs (of which RU-486 is only the first) as regular methods of birth control, so that the abortion rate may well rise even further.

Whatever one's view of the respect due to the unborn—whether or not you agree with my view that they are morally equal to any older human being—this huge scale of killing of the youngest members of our species, family or community, must be a cause for serious concern. These creatures are of us, they are us, they are our potential future. And they cry out for justice, for love, to be remembered.

We should recognise that the results of abortion are by no means homogeneous, nor universally bad: many women (and men, families, societies) experience great relief from fear or threat after abortion, even if they are unavoidably ambivalent. Partly for this reason we should never judge a woman who has had an abortion. We cannot know how really free she was, what options she had or thought she had, what pressures she was under, or how well she understood what was involved. Odds are that she was frightened and lonely, and pressured by a man or parents or our "cop-out" society.

None the less, I think it is important to address the ill effects of abortion because so often the abortion industry and its friends—such as the women's magazines—present a very deceptive picture of abortion as a simple and safe procedure with no real risks for anyone. A wide variety of physical complications are associated with abortion, ranging from death, which fortunately is increasingly rare, to the much less serious but much more

common side-effects such as infections and bleeding and cervical incompetence. There is also growing evidence of considerable increases in infertility and cancer after this intrusive procedure.

The psychological complications from abortion are more significant than the physical ones. At one end of the range are those women who suffer severe psychiatric breakdowns consequent upon abortion: they are rare but with 180,000 women a year having abortions even 0.1 per cent would mean that this is 180 women a year in Britain. At the other end of the range there are those women who report that they experience nothing but relief following abortion. In between there are the majority of women—perhaps three-quarters of them—who suffer various degrees of mild psychological ill effects such as unresolved guilt, regret, anxiety and sleeplessness, often not surfacing immediately but later when the woman first keeps a child or has difficulty having a child. Whatever the literature and the psychiatric associations might say about post-abortion syndrome, the fact is that a growing number of psychologists, counsellors, priests and pastoral workers, many working full-time, are dealing with the aftermath of abortion.

There are two difficulties in assessing the damage wrought by abortion on women. One is that there is insufficient follow-up being carried out: this is simply not a fashionable area of research. Furthermore, the abortion industry and its promoters continue to play down these ill-effects for commercial and ideological reasons. While being pro-abortion is the membership card for the radical women's movement, the very group which one would expect to demand rigorous research and information-giving will be mute on this issue. It is a remarkable fact of women's health history that while women's groups have succeeded in demanding a more thorough examination and wider publication of the ill effects of several pregnancies and contraceptive drugs and devices, as well as surgical procedures such as caesarean sections, mastectomies and hysterectomies, they have allowed the damage done to women by surgical and soon chemical abortion to continue unexamined and uncriticised.

We know that abortion carries risks to future children of premature birth, low birthweight, and physical and mental retardation. Little is known about the effects of abortion grief upon the fathers and other surviving members of the family. There is plenty of anecdotal evidence of ill effects. Despite the predictions that abortion would produce a caring society in which every child would be a wanted child, the incidence of physical abuse of children reported to the NSPCC doubled in the 1980s and is probably still increasing.

The most obvious effect of abortion on medical staff is the provision for some of employment and lucrative incomes. Abortion is a multimillion pound industry and while most doctors refer for abortion, its profits are concentrated in the hands of a relatively small group of professionals who have a strong commercial interest in promoting abortion.

But there are other less advantageous effects. Considerable pressure is brought to bear on staff—especially nurses and obstet interns—to take part in abortion despite their conscientious or emotional objections. To object can cost people their careers. And at the same time we have growing evidence of psychological ill effects on the abortionists themselves, as evidenced by the high staff turnover rates, difficulty of finding staff in some places despite lucrative pay packages, and reports of burnout and psychological disturbance.

The abortion spiral has also had a significant effect on medical ethics. The fundamental orientation of medical practice is less and less the "save life, cure at all costs" imperative of a previous generation and increasingly instead efficiency, productivity, the values of consumerism and the market. There is a demand for abortion so it should be supplied; there is a supply of abortion so it should be demanded. Lack of medical indication for the procedure—whatever the official position of the Abortion Act—is irrelevant. Not that all doctors have embraced this commercial, consumerist medical ethic. But there has been a discernible revolution in attitudes to early human life, previously the doctor's "second patient" presenting with a pregnant woman, in the official position of the BMA and the practice of many doctors. Likewise we are presently witnessing the breaching of the dam wall regarding euthanasia of the comatose, handicapped and elderly.

One group which is radically effected by the abortion spiral are infertile couples. Much of my own research in bioethics has been into the new reproductive technologies: IVF and the like. What has driven this new technology, apart from scientific curiosity? The driving force has been that perhaps one in ten couples in Britain is infertile, and many of these want to bring up children. But adopting has become nearly impossible in the West, with long waiting lists and most couples unlikely ever to get to the top of the list. The reason is primarily that unwanted children are simply not born any more. Solo parenting has also contributed, but the biggest cause of the closure of the orphanages, and thus the frustration of the aspirations of would-be adopting parents, is the high abortion rate.

Another ripple rarely considered is the demographic effect of abortion. Britain is a rapidly ageing society: by the time I am an old-age-pensioner

about half the community will be of old-age-pensioner age. We are doing precious little to prepare for the new kind of community that we will be. Meanwhile, school rolls are declining, schools are closing, the NHS cannot cope with the demand for chronic care, old-age pensions will soon have to be abolished, nursing homes have long queues, the economy lacks vitality and momentum, and a great many social and economic changes resulting from the ageing of the community continue apace.

Why are we getting old so quickly? The demographers tell us that the low birthrate (below long-term replacement level) is more significant than the increased longevity of the population. Why the falling birthrate? Contraception would seem to be the obvious answer, yet the experience of Britain, like that of most countries, has been that widespread contraceptive usage, rather than curbing a supposed "population explosion" simply leads to a "copulation explosion." Paradoxically, the total number of unwanted pregnancies can actually *increase* as a result of the promotion of contraceptive usage. Abortion then becomes the backstop—all the more so in a babies-on-demand culture. If contraception has failed to decrease the rate of unwanted pregnancies, it is abortion which is the real cause of the falling birthrate. Children still get conceived in large numbers, it is just that nowadays many never see the light of day.

Another effect of abortion is on a society's attitudes and taboos. With the abortion spiral has come a demonstrable increase in the acceptance of killing of the innocent and defenceless: infanticide, euthanasia, embryo exploitation, crimes against children and other acts of violence are all spiralling. This reflects a change in popular attitudes to human life and a decrease in instinctual and learnt taboos against homicide.

How has this change taken place? It has been a complex process, involving the gradual moving of the line of who is and who is not a person, a pattern of rhetoric and rationalisation, the use of well-chosen linguistic and ethical evasions, and the dehumanising of certain classes of persons.

We have done this before in various ways at various times. My own country gives one good example. As you may know, the Tasmanian Aborigine was slaughtered to the point of extinction by the British settlers in the nineteenth century. This was publicly justified on two grounds. First it was said that Aborigines were not human, despite all the scientific and philosophical evidence that they were. They were said not to look or behave humanly; not to have the characteristics we value in a human person. Such has been the rhetoric and rationalisation of the exclusion of the unborn from the class of persons in the contemporary discourse in favour of

abortion. There is a similar slide occurring in the language and attitudes concerning the comatose, severely handicapped and elderly.

Not all the settlers in Tasmania pretended that the Aborigines were not human. After all, there was plenty of evidence that a white man could have a child by one! But the Aborigines were said to threaten our quality of life so it was permissible to kill them. Aborigines threatened the quality of life of the white settlers: they stole their sheep, menaced their wives, made off with their supplies. This second string of the genocide bow has its close parallel in today's abortion debate. Many now admit that the unborn is a member of the human family and that abortion is homicide. But they say it is justifiable homicide because the unborn threatens an older person's quality of life. So too we are told do the comatose, the mentally handicapped, Alzheimer's patients and the like.

We generally now regret what we did to indigenous peoples in various lands. Unfortunately we have not learnt from the experience. We are well along the road to excluding whole new classes of human beings from the family of protectable persons.

The last effect of abortion, and perhaps the most important one of all, is the effect of this practice on who we are. Who or what do these decisions say that we are? What do they make us individually and as a society? Moral choices constitute the person and they constitute communities. Even discounting the child killed, abortion is not victimless because the person who does it and the society that allows, condones and supports it are also significantly harmed by the process. A doctor's character will inevitably be very significantly shaped by killing, however noble his or her motives. It will change the doctor's attitudes, habits, dispositions, taboos. A doctor disposed to think that some people lack inherent worth or may be killed has seriously undermined a life-affirming, rescuing disposition indispensable to the practice of medicine. So too with a community. A society which says by its actions that some people lack inherent worth or may be killed has seriously undermined a first principle of justice and community: a willingness to treat every member of that society with equal concern and respect. And the absence of that willingness is likely to be fateful for others. Logically, psychologically and sociologically, socially-condoned medical homicide invites further extension of the killing principle.

The distortion of the relationship involved in the abortion decision allows us to be violent and to be blind to the consequences of that violence, only some of which I have outlined here.

The unborn child is treated as radically unequal, profoundly subordi-

nate, to parents and medicos who decide whether she will live or die. We buy into a dynamic of violence and domination however well we rationalise it. We add a new weapon to the arsenal of discrimination and oppression—against the poor, the handicapped, the unwanted. We accept a patriarchal, liberal, individualistic way of relating: me against my baby, me against my community, my life and my body as my property, the freedom to do as I please is all. We buy into a selective blindness so that we can systematically ignore the sequelæ of abortion and the thousands of wounded women and others.

With the distortion of relationship comes a distortion of values. Smaller, weaker human beings are depersonalised, reduced to the status of commodities or chattels, manufactured, manipulated, and disposed of according to supply and demand. Children become one more consumer item, chosen in so far as they add to the personal satisfaction and growth of their individualist consumer parents.

Hence the case with which our society disposes of so many; hence the spending of millions of pounds on test-tube baby technology to provide a few couples with a child. The distortion of values and relationships which the abortion spiral has occasioned allows the medical-technological establishment on behalf of society to do what, on face value, seems an absurd contradiction: to place two women beside each other in a hospital, the one to suffer profound and humiliating intrusions in an almost frenzied effort to achieve a live birth; the other to suffer profound and humiliating intrusions to ensure that she does not.

This is the final consequence of the abortion spiral: it makes us, as a community, an abortion clinic. That is why, for all the talk about reproductive freedom, we do precious little about provision or encouragement of alternatives to abortion. That is why abortion becomes our knee-jerk response to unwanted pregnancy. That is why we fail to address the causes of the abortion spiral and its ill effects for so many in our society and for our community as a whole. Britain has become an abortifacient: a thing which it is very dangerous for the unborn to get near. And that is at a cost to us all.

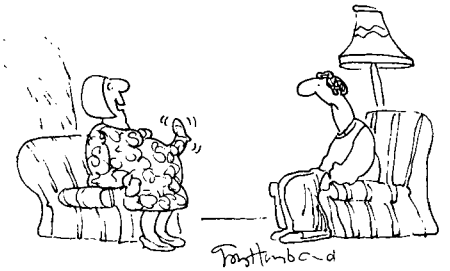
What is to be the response of those who care? What is the response of the Christian?

The Church holds up a mirror to an increasingly violent society. We challenge Britain to look at itself, look what you have become, where you are going. This is the posture of the social critic, the preacher, the prophet. It takes a lot of courage to be so unfashionable, to resist the internal and external pressures to conform. It also requires great humility. It is right-

eous but never self-righteous; holy but never holier-than-thou; of good judgment without being judgmental; rational and frank but never unfeeling; calling people "back" to the values of the Gospel without imagining there was ever a "golden age" free of violence and oppression. It does not assume that our opponents are all and always wicked, ill-meaning or beyond conversion. But it speaks out because killing matters. It matters terribly. It hurts. It destroys. Babies, mothers, whole societies.

Yet the Christian is also driven by a positive vision. She or he is not merely a carping critic. Respect for human life, we know, requires more than just not killing people. Rather it entails many responsibilities. We express our reverence for life not merely in our respect and promotion of the precept against killing, but in our answers to the perhaps harder task of promoting life and love. Motivated by justice and compassion, we seek to build a civilisation of life and love, the making of a world where violence is not seen as an answer: where the treatment of the weak and defenceless is the measure of our community's self-esteem; where pregnancy is no longer seen as a mill-stone around someone's neck but an occasion for rejoicing; where those who have unplanned pregnancies are supported in every way possible through those nine months and for years beyond.

We wait for the coming of that Kingdom where the wolf shall dwell with the lamb, and the leopard lay down with the kid; when men will beat their swords into ploughshares, their spears into pruning hooks; when nations shall not lift up sword against nation; when the peacemakers will be called children of God. Such a positive vision is demonstrated in our rhetoric and our action when we promote the Christian pro-life vision in all its dimensions and act to ease the burdens of those driven to despair. In word and deed we live for the day when we can use again that ancient folk metaphor for security, "safe as a child in its mother's womb."



'Darling, look it's kicking!'

THE SPECTATOR 28 January 1995

APPENDIX A

[*The following article first appeared in the* Wall Street Journal *(January 16, 1995), for which Barbara Carton is a staff reporter. It is reprinted here with permission (© 1995 Dow Jones & Company, Inc. All Rights Reserved).*]

The Dollars and Cents of the Abortion Business

Barbara Carton

Susan Hill is explaining to a phone caller why she pays thousands of dollars a year to fly in out-of-state doctors to work in her Fargo, N.D., abortion clinic—no doctor in North Dakota wants the job, she says—when she is called to another phone. A minute later, she is back. "Our Indiana clinic was calling about a bomb threat," she says.

Abortion is one of the great dividing issues of our time, a moral battleground and a political hot potato. But it is also something more: a $450 million business. Each year, roughly 1.5 million abortions are performed at an average cost of $300 each. Ninety percent are performed by independent clinics, many of them for-profit, as are the nine clinics that constitute Ms. Hill's National Women's Health Organization chain.

In some ways, the Fargo facility is atypical of the nation's mostly urban abortion clinics. Perched alone at the edge of the prairie, its clients include farm women who often drive for hours to reach it. The Fargo clinic's violent history, including two firebombings, also sets it apart. Flip Benham, director of Operation Rescue, the anti-abortion group, calls Fargo "the one mill in North Dakota, period. And we are looking for one state to finally be abortion-free."

Nor has isolated Fargo been hit with the same declines that have affected the abortion industry generally, says Ms. Hill, who is 46 years old. By 1992, the latest statistical year, abortions nationwide had fallen to the lowest levels since 1979—1.5 million—because of demographic and attitudinal changes, including society's increased acceptance of unwed mothers. The resultant cutthroat competition among abortion clinics for that business is so fierce that the National Coalition of Abortion Providers, a trade group, has added a popular "Marketing Tips" column to its newsletter.

But Fargo illustrates in broad terms some of the business issues facing abortion providers—primarily, the substantial and fluctuating costs associated with pressure from abortion foes. Ms. Hill says her company, which is based in Raleigh, N.C., and has centers in eight states, is profitable overall. But last year, Fargo, a perpetual loser, lost another $16,000 on revenue of $500,000. Other centers around the country are also struggling financially, according to one industry trade group. Neither Ms. Hill nor other abortion providers will say how profitable their businesses are, in part because they fear retaliation.

Of the Fargo clinic's 1994 revenue, 25% came from routine gynecological procedures and the remainder from abortions, for which the clinic charged $400

for a first-trimester operation. But offsetting revenue were annual expenses that include the $100,000 paid to her chief doctor for working two days a week and $11,000 for two armed guards to roam the clinic on days when abortions are performed. Security expenses would have been higher, Ms. Hill says, if U.S. marshals hadn't stepped in to help five months ago.

Before 1992, Fargo's security costs were negligible because Ms. Hill relied on volunteer escorts. In 1993, alarmed by the abortion movement's first murder, her security budget mushroomed to $30,000, as she outfitted her three doctors with $750 bulletproof vests and installed door buzzers and surveillance cameras. This year, she is already anticipating a doubling of the 1994 security budget to cover a $3,000 metal detector, plus an operator's salary, in the wake of the two Brookline, Mass., abortion-clinic slayings in December.

Like security costs, legal bills fluctuate wildly. Three years ago, Ms. Hill paid $50,000 in the aftermath of demonstrations by the militant Lambs of Christ and other groups. Last year, she paid $23,000—"that was just for ongoing things, like when people are chained to the building." At any given time, the clinic is embroiled in anywhere between one and four legal actions with protestors, says her lawyer, William Kirschner.

"Every issue, they make crazy motions," he says. "They argue about everything. They are basically trying to bankrupt the clinic." Recently, for example, Ms. Hill says she was forced to take several men to court for trying to block Fargo's entrance by attaching themselves with bicycle locks to junk cars.

Fargo's property and casualty insurance costs hovered at $2,000 for 1994, about the same as the previous year, despite two incidents of arson and a vandalism spree by abortion foes that left the clinic covered with scrawled slogans. Although Ms. Hill says she doesn't turn in claims under $5,000, she says that Fargo's insurance has been canceled several times over the years: she won't provide the names of her current insurer.

While she has never had trouble finding an insurance replacement, other providers have, particularly with big companies. For example, Travelers Inc.'s Travelers Insurance Co. says it stopped underwriting abortion clinics in 1990.

"I wouldn't say what we're facing is a wholesale dumping of abortion clinics by the insurance industry," says Susan Silver, director of member services at the National Abortion Federation, an advocacy and trade group. But Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, another trade group, guesses that 20% of his members are going without coverage because they can't find it. "It has gotten to the point now where we are discussing setting up our own insurance company and having the clinics self-insure," he says.

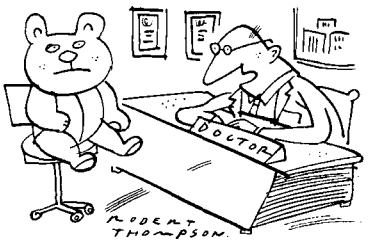
Like any business, Ms. Hill also has marketing costs—especially important when demand is falling and competition is increasing. Advertising last year cost $48,000, roughly the same as for 1993, including a Yellow Pages display, college newspaper ads and a local commercial on the MTV cable channel—a first for the Fargo clinic and, according to Ms. Hill, a success.

Increasingly, though, patients are coming from health-maintenance organizations and physician referrals. Ms. Hill's colleagues say she has been in the forefront of clinic owners rushing to network with doctors and sign up HMOs (which commonly pay for abortions), with 50 contracts so far. Hoping to capture even more HMO business, Ms. Hill is also diversifying, transforming some of her clinics (not yet Fargo) into ambulatory surgical centers that can perform a range of gynecological procedures like fallopian-tube tie-offs.

Fargo's administator, Jane Bovard, says the clinic isn't considering raising its abortion fee because it is already among the highest in the country and the highest in Ms. Hill's chain. Any increase, Ms. Bovard says, would put the fee "out of sight," and women don't have much of an alternative, since the nearest clinic is hundreds of miles away, in the Minneapolis-St. Paul area.

Among Fargo's more mundane expenses are janitorial costs ($3,400 in 1994), office supplies and expenses ($4,500), accounting ($1,500) and repairs ($2,000). The clinic's rent was unchanged last year at $30,000, although it will go up $2,400 for 1995; and landlords throughout the country are proving increasingly skittish about renting to abortion clinics. When Fargo first opened, Ms. Hill says she tried unsuccessfully to rent at least 30 different facilities and took the only suitable offer she got—a two-story house, across from an electronics store. She has also tried to buy, but says that no one will sell, even when she offers higher than market price.

Ms. Hill says she hasn't wanted to force the issue in court. "The last thing we want is another fight," she says. "How many fights can we handle at one time?"



'Sorry to have to ask you this, but how many people have you slept with?'

THE SPECTATOR 14 January 1995

APPENDIX B

[*The following column appeared in* U.S. News and World Report *on March 6, 1995. It is reprinted with the permission of the author, who is a contributing editor of* U.S. News *and a nationally-syndicated columnist.*]

Foster furor bears a reminder

John Leo

The nomination of Dr. Henry Foster is the best news in years for people who oppose abortion on moral grounds. To the amazement of both sides of this long dispute, it has revealed that a great many Americans really don't think an abortion practitioner ought to be surgeon general.

Especially since C. Everett Koop served in this office, it has become clear that the main function of the office of surgeon general is moral exhortation. On the basis of popular reaction to this nominee, the nation wants its medical preaching done by someone who comes to the job with cleaner hands than Henry Foster.

Proponents of abortion have been blindsided by this, largely because they came to believe their own press releases that only a tiny fringe of "out of the mainstream," "anti-choice" zealots still resist the hardening pro-abortion consensus.

What the pro-choicers rarely acknowledge is that the nation is much more troubled than that about abortion. Depending on how the pollsters frame their questions, up to 75 percent of Americans have moral objections to abortion on demand. Becuase Donna Shalala and her staff don't seem to know any of these people, they think what everyone in their circle thinks: Abortion is a non-issue now.

This is a bit like the embarrassment suffered by the Washington *Post* when it failed to notice a huge anti-abortion rally a few blocks away because nobody on staff seemed to know anyone who planned to attend. In some tight little circles, it takes a huge act of imagination to notice what the rest of America thinks.

The public's resistance to Dr. Foster is based on a very simple premise: that an administration stacks the decks in favor of abortion when it names an abortionist to a job known primarily for its moral preaching.

This reaction has been obscured, in part, by Dr. Foster's apparent inability to come clean on the number of abortions he has performed and by the news that he performed some other ethically dubious operations before 1974: the sterilization of four healthy but mentally retarded women.

But this has just reinforced the strong feelings about Dr. Foster: It has associated abortion with furtiveness, evasiveness, and an apparently casual attitude about involuntary sterilization.

Dr. Foster is not going to be surgeon general, but his nomination has accomplished two things: It assures us that the next surgeon general will be someone

who has no record of performing abortions, and it opens the door to the use of stigma as an organized anti-abortion tactic.

Stigma doesn't get very good press in America. The left keeps insisting it is an attempt by the powerful to assail the behavior of the powerless. But the left conducts stigma campaigns of its own all the time—against smoking tobacco and wearing fur, for example. We are on the brink of a broad effort to restigmatize easy divorce and the intentional bearing of children out of wedlock. Why not a campaign to stigmatize something even more dubious: solving a problem by killing a developing form of human life?

Some anti-abortion activists have been pursuing a stigma policy by publicizing the names of abortion doctors. Nothing wrong with that, unless the effort veers over into the harassment of families and threats against doctors' lives. It's probably true that many doctors have stopped performing abortions out of fear of quasi-terrorist tactics against them. But many more doctors are shying away because of the stigma.

The truth is that abortion is generating a generally bad odor in the medical profession, in large part because doctors understand very well that it is a morally dubious procedure. Dr. Ralph Hale, executive director of the American College of Obstetricians and Gynecologists, estimates that more than half of the group's 35,000 members have performed abortions in the past, but only a third are doing abortions now. That would be roughly 5,000 Ob-Gyns who have stopped doing abortions. Some are older doctors with patients past their childbearing years. But these older doctors are not being replaced by younger ones as eager to do abortions. Is this because they are all terrified of anti-abortion violence, or is the shame of performing this operation beginning to take a heavier toll?

The current effort by pro-choicers to force medical students to learn how to perform abortions is a way of saying that the money to be made in performing abortions is not drawing enough doctors into the field.

Anti-abortion forces would be better off abandoning harassment at the clinics and the futile efforts to get an anti-abortion amendment or Supreme Court ruling. What we need is steady moral pressure, built around stigma, to reduce the number of abortions and to depict abortion as a primitive form of violence that society will eventually outgrow, just as it outgrew infanticide and slavery.

This would mean no state funds at all for abortion, and no more state-supported abortion festivals like the population conference in Cairo. The state would have to stay totally neutral, and not pretend, as it did in the foolish Foster nomination, that the issue is somehow behind us.

APPENDIX C

[*The following column appeared in the* Arizona Republic *(January 19, 1995), on which William P. Cheshire is senior editorial columnist. It is reprinted with permission (© 1995 Arizona Republic).*]

In choosing abortion terminology, the devil's in the details

William P. Cheshire

An offended reader left a message on the voice mail the other day, challenging my use of the term "pro-abortion" to describe those people who, in common with a majority of the U.S. Supreme Court, see abortion as a legitimate constitutional right.

There's a significant difference, he maintained, between being pro-choice and being pro-abortion. Furthermore, he said, either I recognize that distinction or I'm stupid, "and you're not stupid."

He'll get an argument there, but I appreciate the compliment. Even so I must take issue with him on the use of the term "pro-abortion."

As a practical matter, the hair-splitting between "pro-choice" and "pro-abortion" is a distinction without difference, which is why I didn't flinch from the terminology I used.

Either one favors non-therapeutic abortions, opposes them or doesn't care. Those who see abortion as an acceptable, constitutionally protected means of terminating any unwanted pregnancy necessarily fall into the pro-abortion category.

The easiest and most familiar analogy is the American experience with slavery, though other comparisons might be made.

Especially if their families were of the planter class, Southerners—I'm one myself—commonly retreat into a form of denial when confronted with the slavery question.

Their ancestors owned slaves, they will maintain, but they weren't really pro-slavery. It's just that the economics of cotton and tobacco cultivation made manumission a practical impossibility, don't you see?

I've listened to this comforting mythology all my life, sometimes in the bosom of my own family. I find the reasoning unpersuasive.

To be sure, manumission could be inconvenient and expensive. Before freeing a slave, the Virginia planter had to post a substantial bond so that his neighbors would not be penalized if the liberated slave, instead of hiring himself out, ended up relying on the charity of others.

Yet it was always possible for the unwilling slave owner to liberate his chattels if he was sufficiently motivated.

If he lacked the requisite bond, he could take his slaves to another state—if necessary to a free state. George Washington quietly manumitted the household slaves he had taken with him to Philadelphia and New York simply by not bringing

them back with him to Virginia.

In short, owning slaves was a voluntary act. Nothing required it, and those planters who truly opposed slavery—and there were some—were able to surmount all obstacles to setting them free.

This being so, what are we to make of those planters who continued to own slaves, but were uncomfortable with slavery and perhaps spoke out against the "necessity" of it? Should they be thought of as pro-slavery or anti-slavery?

I say they were pro-slavery, along with all those Americans outside the South who regretted slavery, but reasoned that Southerners had a constitutional right to own slaves and that the abolitionists had no right to interfere.

There were degrees of support for slavery, of course, just as there are degrees of support for abortion. Aside from slave traders and planters, who made a good living from it, few Americans can have viewed slavery as a positive good. Just so, most "pro-choice" Americans, outside the $450 million-a-year abortion industry tend to think of abortion as a regrettable, though defensible, alternative to unwanted children.

This doesn't mean that they regard the incidence of abortion—1.5 million yearly in this country—as insufficiently large and so would agitate on behalf of additional feticides. Many probably wish that all those babies had been wanted so that their extinction would have been "unnecessary."

They're still pro-abortion for the same reason that the antebellum American didn't become anti-slavery by supporting the "right" of planters to practice slavery while hoping they wouldn't.

The same principle applies to capital punishment.

It's unconvincing to say that you don't favor state executions and wish people would stop committing grisly crimes so that the death chambers could be shut down. People who oppose capital punishment oppose it for Jeffrey Dahmer, who cannibalized his many victims, just as they oppose it for everyone else.

My caller, I fear, is stuck with the pro-abortion label, like it or not.

APPENDIX D

[Art Caplan is director of the Center for Bioethics at the University of Pennsylvania. This column first appeared in the Philadelphia Inquirer *on December 8, 1994, and is reprinted here with permission (© 1994 King Features Syndicate).]*

Voters have opened up a Pandora's box that they may long regret

Art Caplan

Long after anyone remembers who was elected to the 104th Congress of the United States, and long after folks have forgotten what exactly it was that possessed them to vote for the likes of Newt Gingrich and Ted Kennedy, 1994 will be remembered as the year in which a state made it legal for physicians to assist in the death of their patients.

By passing Ballot Measure 16, the citizens of Oregon voted to allow doctors and pharmacists to provide lethal doses of pills on demand to the terminally ill. My hunch is that the citizens will come to regret that vote more than any other they cast.

The strength of the new law is that it puts the burden for ending life squarely on the patient's shoulders. Ghoulish Kevorkians with gas masks, death machines or lethal injections need not head West. Those making a request to die must get their prescription filled and swallow the pills themselves. The law tries to protect against abuse or a mistaken request by requiring that two doctors state those asking to die have less than six months to live. It also mandates that those making a request be counseled about their options and alternatives, including hospice and palliative care. The law also requires a determination that the patient is mentally competent and acting voluntarily. And it calls for a 15-day waiting period before any prescription is written.

Those protections might seem adequate but they are not. The residents of the Beaver State may soon learn that it is easier to pass a law legalizing assisted suicide than to implement one.

The law leaves many legal issues unsettled. For instance, only requests made by Oregon residents are to be honored. But some terminally ill people are likely to go to Oregon in order to get their lethal dose of barbiturates. How residency is to be defined and whether those in the state can carry or mail pills out of Oregon should keep lawyers from Kismath Falls to Portland working overtime.

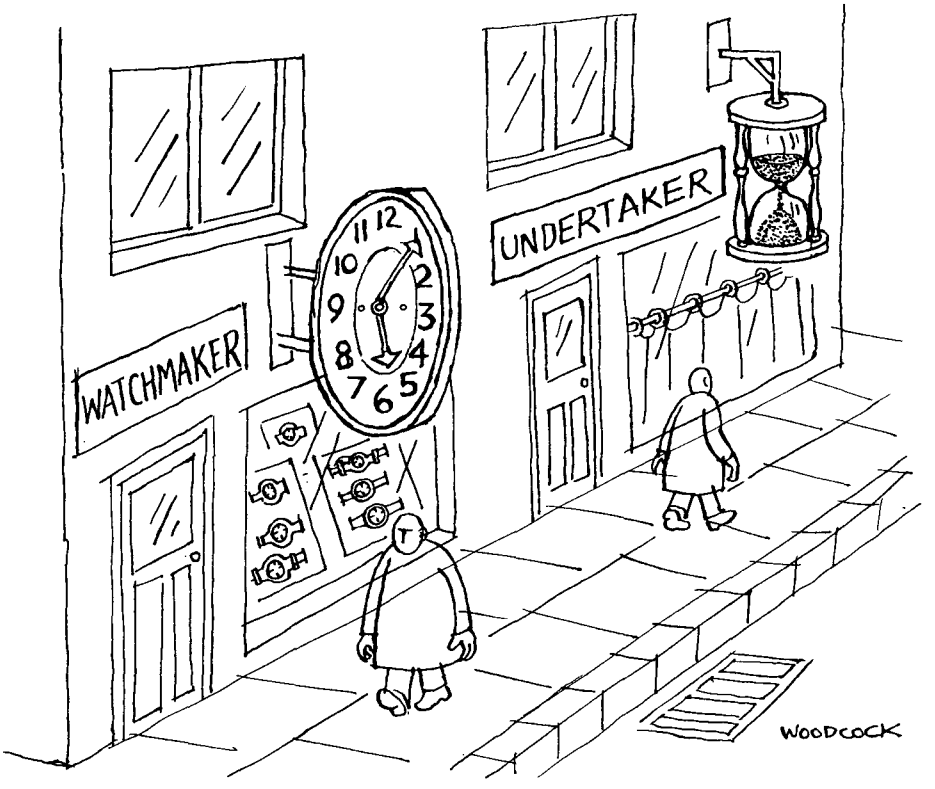
Another area ripe for abuse is the use of the term "terminal illness." It is notoriously difficult for doctors to predict who has less than six months to live. It will be much easier to comply with the law if a doctor wants to act in bad faith rather than good. Those who want to exit the Northwest for good or who would like to see mom or dad do so, might be able to find unscrupulous doctors to help them along.

Perhaps the most frightening aspect of Oregon's new law is the fact that the

state is also a pioneer in health-care rationing. A few years ago Oregon came up with a program to broaden access to health insurance for the uninsured poor by limiting the benefits and treatments available to those who rely on Medicaid for their health care.

As a result of pressures to contain costs, the poor, the disabled and the elderly who are terminally ill in institutional settings may well find themselves under a great deal of tacit pressure to end their lives in order to spare the state the cost of their dying.

Death in Oregon has become easier. Whether it will be more dignified or humane remains to be seen.



THE SPECTATOR 25 March 1995

APPENDIX E

[The following column appeared in the Los Angeles Times *on November 27, 1994 and is reprinted here with the permission of the author. Mr. Weigel is president of the Ethics and Public Policy Center in Washington, D.C.]*

A Brave New World Is Hatched

George Weigel

At the beginning of Aldous Huxley's classic novel, as at the entrance to the brave new world it depicts, there is the "Central London Hatchery and Conditioning Centre." In a "squat gray building," 300 technicians bend over their microscopes, managing the process of human reproduction. The technicians inspect human eggs, then immerse them in a "warm bouillon containing free-swimming spermatozoa." The fertilized eggs—human embryos—are then incubated until they are ripe for bottling and development.

The suburban campus of the National Institutes of Health, just outside Washington, is a handsome park; there are no ugly, squat, gray buildings to mar the sylvan landscape. But what the NIH proposes to undertake is nothing less than the creation of a real-life American analogue to Huxley's Central London Hatchery. For, later this week, the advisory committee to the director of the NIH will almost certainly adopt the recommendation of the NIH Human Embryo Research Panel that the federal government sponsor and fund the laboratory creation of human embryos as research materials for experimentation.

This research, the panel alleges, will have all sorts of benefits: reversing infertility, enabling us to make more perfect babies, even contributing to the fight against cancer. Other scientists disagree that the potential payoff is considerable. But even if the scientific benefits were as great as the NIH panel claims, the burning question would remain: Is it ever morally acceptable to create human lives for research experimentation that will, inevitably, destroy them?

Most people instinctively recoil in shock and disgust, even horror, from such a proposal. That reaction should be encouraged, not deplored. It bespeaks not scientific illiteracy but moral common sense. High school English students find Huxley's fictional future frightening because in it, men and women have been thoroughly instrumentalized, made into means for someone else's ends. Yet that is precisely what the NIH proposes to sponsor, using taxpayer funds to pay the freight.

The NIH panel acknowledges that, should its recommendations be followed, scientists will be creating, manipulating and then destroying "developing human life" that deserves "serious moral consideration."

But evidently not too much consideration, for this human life, the panel argues, lacks "personhood." Personhood, according to panel member Ronald Green of Dartmouth, is not a set of "qualities existing out there" but something that "we" bestow on a human creature. Whether someone is too old, too young, too burdensome or too useless to be afforded the protections given to persons is something that "we" decide, on the basis of enlightened self-interest. "Personhood" is not an inherent quality of human beings;

"personhood," on Green's analysis, is a "social construct."

We have been down this grim road before. The 20th Century is replete with examples of what happens when one group (or caste or race or party) declares itself to be the vanguard to whose superior purposes others must bend, even to the point of their extermination.

The great slaughters of our era—of Jews, Gypsies, Polish intellectuals, Ukranian kulaks, Armenians, bourgeois Chinese, Hutus, Tutsis—all took place when the humanity of indisputably human beings was denied by powerful others, who were acting, so they thought, on sound scientific or philosophical or theological principle.

There are some things that should never be done by anyone, under any circumstances, for any reason, in aid of any possible benefit. One would have thought that, in the wake of Nazi quackery, the exploitation of human beings as research material would be understood as one of those things. But now the NIH Human Embryo Research Panel proposes to go a step further by deliberately creating human lives whose only purpose is to serve as disposable research material.

In so doing, the panel endorses a direct violation of the Nuremberg Code, which, inspired by Dr. Josef Mengele, unambiguously declared that "no experiment should be conducted where there is . . . reason to believe that death or disabling injury will occur."

The use of human beings for experiments that will harm them and to which they have not consented should be prohibited by law. So should the technological production of innocent human beings as research materials. Congress must act; the NIH, alas, seems incapable of recognizing either scientific hubris or crude utilitarianism masquerading as moral reason.

'How do you like your eggs?'

THE SPECTATOR 5 November 1994

APPENDIX F

[*The following Op-Ed column first appeared in the Washington* Post *on March 8, 1995 and is reprinted here with the author's permission. Benjamin J. Stein is a writer and actor in Los Angeles, and also teaches law at Pepperdine University.*]

Deep-Sixed by the GOP

Benjamin J. Stein

"A bureaucrat is a Democrat who has a job that a Republican wants." So said Eleanor Roosevelt in 1946, when she was helping to campaign against the Republican tide in Congress. It didn't help, but it made a valid point. There's no particular pride in coining phrases and slogans and posturing after moral superiority if all you really want is a job and the pose of moral superiority is your pitch.

This comes to mind because of a recent spate of backpedaling among Republicans about the right-to-life issue. From what I hear, it's coming from across the board, in Congress and elsewhere, and there is not a single GOP presidential hopeful at this point who is in favor of a right-to-life amendment to the Constitution or of repealing *Roe v. Wade* in any way.

Now, to some of us, abortion is the preeminent moral issue of the century. It's not a medical procedure of moral neutrality. It's not a sad duty that conflicted mothers sometimes have to do. It's the immoral taking of a life, not very different from homicide. Since it's done by doctors and by mothers, it's particularly hypocritical. Since it's the taking of totally helpless life, it's the breaking of the most sacred trust imaginable—the implicit pledge by parents to take care of their children, or at least not to murder them.

Stopping this riot of immorality is not just another issue like how many pages of regulations there should be on handling chicken byproducts. It's not an issue about which learned people differ—but none considers either position immoral—like the balanced budget amendment. It's the bedrock for many of us whether we can consider ourselves a moral people. It's as vital for our time as abolitionism was for the America of a century and a half ago. From it flow all other considerations of how much importance we place on human life.

Obviously not everyone agrees with us about this issue. There are some politicians, like Barbara Boxer and Diane Feinstein, who have always opposed right to life and tried to make the case for abortion. That's not fine, but at least it's understandable. There is some consistency there, and although it's consistency for a wicked principle, it's understandable.

What's more troublesome right now is this screaming fact: The Republicans ran under the right-to-life banner. They gave money to right to life to turn out the pro-life vote. They got an astoundingly high percentage of the right-to-life vote. It's not an exaggeration to say the right-to-life vote put the Republicans in power in Congress.

Seemingly, now that the GOP is in the jobs that the Democrats had, the right-to-life voters can be safely cast aside. ("Where else do they have to go?" as a Republican strategist here said to me. "We aren't going to lose them to Hillary Clinton.") There will be some minimal bows to not using taxpayer money to pay for abortions, but the federal government will not use its power to hinder privately paid abortions. (Even though the federal government pokes its snout into the nongovernment sector minute by minute, person by person, across America.)

The notion here, as I keep reading, is that abortion is a divisive issue, the kind of issue that gets people angry, that splits the party and that loses elections if it's pressed.

Or, to put it another way, maybe abortion is the kind of issue that prevents a Republican from getting a job that a Democrat has. But wait a minute: If it's true that the GOP ran on a pose of moral superiority, got elected on that pose and is now going to deep-six the issue it posed on so as to go on to further electoral triumphs, don't we have a word for that? Isn't the word hypocrisy—hypocrisy about a moral issue that keeps people up at night, that makes people go to jail for what they believe?

Somehow, I don't think that all the cutting of the budget, reduction of taxes and building up of the military will wipe away the stain. The GOP has seemingly just used the most morally sensitive issue of the century as a ploy to get votes. When it looks as if the issue might lose an election, even if the pledges were unequivocal, the issue and the faithful get dumped. It's frighteningly cynical.

But now we know. Get the votes and run. A bureaucrat is a Democrat who has a job that a Republican wants. That, apparently, is the bottom line.

APPENDIX G

[*The following column first appeared in the New York* Observer *on January 30, 1995. It is reprinted here with permission (©, 1995,* New York Observer*). Mr. Brookhiser is a senior editor of* National Review.]

Can the Pro-Lifers Win? Remember John Brown

Richard Brookhiser

John Salvi murdered two agents of Planned Parenthood, but they were only secretaries, not abortionists. Whether that makes him a greater or a lesser warrior against the abortion Moloch than Paul Hill is a question for the casuists of the pro-death wing of the pro-life movement to decide. The rest of the movement will keep fighting the anti-abortion struggle the only way it can be won: morally and politically.

How vain the most recent pro-life murder looks, set against the career of John Cardinal O'Connor, who has just turned 75. When Mario Cuomo used to give homilies explaining how the laws of God and the wisdom of the Founding Fathers required him, as a politician, an intellectual and a Catholic, to do what the Democratic National Committee wanted done that week, it was Cardinal O'Connor who called him to account. On the abortion issue, the Cardinal has spoken truth to power (as they say in the seminaries). Though it will shock Catholic New Yorkers—who scarcely ever meet a Protestant who is not from Bed-Stuy or Trinidad—so have Jerry Falwell and Pat Robertson.

Yet for all their speaking, hasn't abortion become ever more entrenched in American law and behavior? So the Salvis and the Hills of this world ask and, having answered their own question, act. But America has been here before. Slavery had also become more entrenched, over the first 74 years of the republic; from a practice that shamed slaveholders like Thomas Jefferson, it became an institution that Southerners praised and many Northerners winked at. A Supreme Court as bumptious as the one that decided *Roe v. Wade* ruled that the Constitution protected slavery in the territories.

There were enemies of slavery who responded to that tide of bad fortune just as John Salvi did. John Brown, whose soul goes marching on, began his earthly march by murdering five slaveowners in Kansas and ended it by seizing a Federal arsenal. Though his course was bloodier than Mr. Salvi's and equally-unavailing, he fared better at the hands of the literati. "For once," said Henry David Thoureau, in a rapturous eulogy of the old ruffian, "we are lifted out of the trivialness and dust of politics into the region of truth and manhood." In sober fact, the fight against slavery was won not by bloody fanatics and the intellectuals who honored them, but by Abraham Lincoln and the trivial and dusty politicians of the Republican party. It was they who sold the electorate on a contract with America forbidding the expansion of slavery. Only when the South refused to abide by the result did they feel compelled to prove their manhood.

It is up to the Grand Old Party now to follow the course it followed when it was a Grand New Party. Yet in its heart of hearts it wants nothing of the kind. Republicans were content to fight against abortion when the job could be left to judges. But now that the pro-abortion swing vote on the Supreme Court consists of Justices Sandra Day O'Connor, Anthony Kennedy and David Souter, all appointed by Ronald Reagan or George Bush, Republicans throw up their hands in dismay and count on recapturing the White House with welfare reform, balanced budget amendments and, perhaps, the pensées of Senator Gramm's homespun chum, Dicky Flatt.

Hence the double importance of former Gov. Bob Casey of Pennsylvania, who hopes to challenge President Clinton in the 1996 Democratic primaries on a pro-life ticket. Mr. Casey's power to attract odd pockets of support in his own party was demonstrated at a Warhol Foundation dinner in Pittsburgh during his second term. At one table were the representatives of New York money and high culture; at another were the Warhola family, the artist's factory-worker relatives. Governor Casey sat up with the nabobs, but all during the meal, Warholas came up to him to applaud his stand on abortion. So did Ultra Violet, a veteran of the other Factory.

Throw in Nat Hentoff, and Mr. Casey ought to be able to run at least as well as Bob Kerrey did in the last cycle. But a Casey candidacy will affect the Republicans too, by keeping them honest, and by reminding the Patakis, the Whitmans and the Welds that pro-lifers can get elected to executive office, even in the Northeast.

What Republicans can do is to stop pushing abortion abroad and subsidizing abortion counseling at home. They can make sure that efforts to stop anti-abortion murders do not become a *Kulturkampf* against the pro-life movement. Republican governors can push for Casey-style waiting periods and parental consent requirements for minors. Most important, Republican spokesmen can make the moral and political case against abortion in such a way that Congress will be enabled to take the issue from the courts—either under Article III, Section 2 of the Constitution ("The judicial power shall extend to all cases . . . with such exceptions, and under such regulations as the Congress shall make") or under Section 5 of the 14th Amendment ("The Congress shall have power to enforce, by appropriate legislation, the provisions of this article")—and give it to the states.

Look, I can understand the Republicans. If it were a matter of feelings, I wouldn't want to make the anti-abortion case either. I am neither Catholic nor evangelical; I do not come by it as a matter of faith. The iconography of Operation Rescue leaves me colder than Mrs. Clinton's lips. It strikes me as a combination of devotional sadism and the sickliest of Victorian child worship: St. Sebastian meets Little Nell. My aversion has a foundation in conservative principle, or one strain of it. Edmund Burke told us to be most mindful of the "little platoon," the people you know and deal with, who are reduced to digits in the

calculations of ideologues and visionaries. Who could be more remote from the little platoon than someone I have never met, someone who hasn't even been born? I can talk to his mother; I can't have a drink with a sonogram.

But the facts block all exits. The fetus may not be a person, philosophically or in the eyes of the law. But it is certainly a human being. It is a being: It lives, it grows, it grows *up*; leave it nine months, it will cry. It has to be human, unless we believe in impregnation by Jove, or by demons. That means it deserves better than to be thrown in a dumpster.

Here I stand, because I cannot do otherwise. And the Republican Party should stand here, too. What good will all our tax cuts do if we permit a social policy of such carelessness, founded on such a denial of reality? How can we cash savings from the welfare budget when we're cashing out human beings? Will the epitaph of the Gingrich Era be that the G.O.P. got term limits, while a million and a half human beings a year continued to get life limits?

"The trivialness and dust of human politics" redeemed John Brown's moral debacle in 1860. It must redeem John Salvi's now.

'No, my little sexpot, "harassment" has one *r and* two *s's.'*

THE SPECTATOR 12 November 1994

APPENDIX H

[*Mr. Wright is a senior editor of* The New Republic, *in which this article first appeared (October 24, 1994). It is reprinted with permission* (© *1994,* The New Republic).]

Mr. Clean Genes

Robert Wright

Suppose you are a young married woman and have just found out that you carry BRCA1—the gene that brings an 85 percent chance of getting breast cancer. You already wanted to have children, and now, feeling suddenly mortal, you're especially eager. But you don't want to pass the gene on to them, and you realize there's a way to avoid that. Using in vitro fertilization, you can create several test-tube embryos, each consisting of only a few cells. Then you can screen the embryos for the gene and reimplant those that pass the test.

Should you do it? The answer depends, for one thing, on whether you've got $10,000 to spare. This may sound like a mundane question compared to all the moral imponderables one could ponder here, but in it lies much of the political significance of the recently discovered, much-discussed breast cancer gene. Along with other pathological genes just coming to light, it will make a new kind of argument for universal health care—and, if the argument prevails, will draw the government into the business of eugenics. In the process, the ideological character of eugenics will be redefined.

It will be a year or two before doctors can easily screen people, and thus embryos, for the breast cancer gene. But once these tests exist, they will no doubt be used eugenically. The precedent was set in 1992 by a British woman carrying a gene for cystic fibrosis. Eight embryos were screened for the gene, two were reimplanted, and one survived to birth—a baby girl with healthy lungs.

There are two reasons few women have followed this precedent. First, discovery of the cystic fibrosis gene has led to a nasal-spray treatment for the disease, dampening the eugenic incentive; no such therapy is likely anytime soon for breast cancer. Second, there are only about 1,000 new cases of cystic fibrosis in America each year. Ten times that many women contract breast cancer because of BRCA1, and a like number because of BRCA2, a gene scientists are close to locating. And then there's MSH2, the gene that gives you an 80 percent chance of getting colon cancer. It was discovered last year, and a test for it should arrive before long.

And so on. More and more genes will tempt more and more people to clean up their little corner of the gene pool. Barring government intervention, the pool will get clearer around the affluent but not around the poor. Of course, there's nothing new about health care options being open mainly to the upper socioeconomic classes. You seldom run into a homeless person at a brain-scan clinic. But surely there's something uniquely, intolerably grotesque about creating a genetic underclass, letting a broad range of hereditary diseases settle at the

bottom of the social hierarchy.

If you agree, you're left with two choices: either ban eugenic intervention, ensuring that, say, cancer remains an equal-opportunity attacker; or provide money for people who want eugenics but can't afford it. I vote for the latter. And if you vote for the former, you can have the job of telling women with the breast cancer gene that they're not allowed to spend their hard-earned money to spare their daughters the same fate.

Once you start subsidizing eugenics, lines get hard to draw. Mark Skolnick, head of the team that found BRCA1, suffers from "Syndrome X," a genetic defect that encourages heart disease and often kills men in their 40s and 50s. At 48, he sticks to a no-fat diet and hopes for the best. Presumably he'd like any future off-spring to live less precariously, and presumably that option will be open once the X gene is found. But what about genes that less dramatically incline us toward heart disease? Skolnick co-founded Myriad Genetics, the company that patented (yes, patented) the BRCA1 gene and will develop a test for it. The company has observed: "The market for testing for the genetic predisposition to cancer, heart disease and other significant diseases potentially includes the entire population."

Indeed. Bringing test-tube eugenics under the rubric of health care will drive home with new force the fact that providing universal coverage isn't cheap. It will also drive home the usually unspoken corollary: providing universal and *comprehensive* coverage is impossible. Hence, more vivid than before, the case for rationing, for discouraging high-cost, low-benefit treatment. Given fiscal reality, we may face a choice between (*a*) keeping a cancer patient alive for an extra week and (*b*) sparing an unborn child from eventual cancer. To me, (*b*) seems the clear winner. On the other hand, when you change (*b*) to "sparing an unborn child from a slightly elevated risk of heart disease," the issue gets trickier.

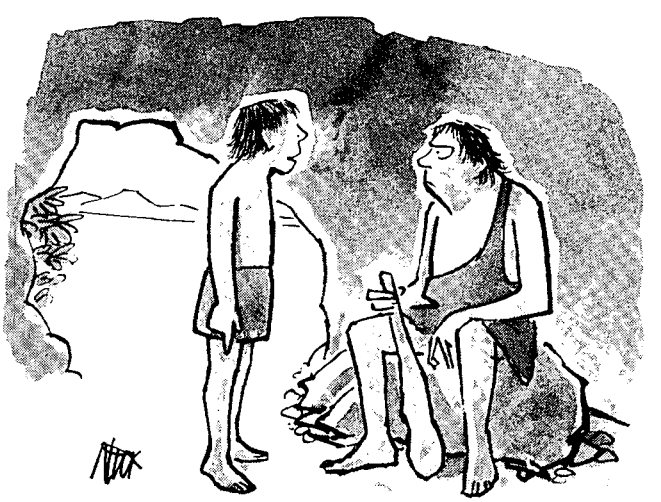
Test-tube eugenics eventually will touch temperament and intelligence. And though a gene strongly inclining one toward manic-depressive illness or mental retardation might be an easy call, other genes won't be. The geneticist Robert Plomin is studying children with low and high I.Q.s, trying to find a cluster of genes that together appreciably influence intelligence. He says he's getting closer. Should the government support *this* sort of eugenics? And if not, are we willing to see only the affluent use it? (Just what rich people need: expanded educational opportunities.) We could try to ban such uses altogether, but such a ban will be politically hard to sustain if wily international competitors—German, Japanese, Chinese—start permitting this sort of intellectual enrichment.

Eugenics used to connote coercion, the selective *restraint* of reproductive opportunities. The famous 1927 Supreme Court ruling that "three generations of imbeciles are enough" came in support of a state law dictating involuntary sterilization of the "feebleminded" in public institutions. And sometimes, to make matters worse, the grounds for selection were ethnic, as with immigration laws. These racist overtones are one thing that dried up the surprisingly strong early

liberal support for old-style eugenics and turned it into a right-wing enterprise.

The new eugenics, in contrast, will *expand* reproductive options and do so in order to keep them level across socio-economic and ethnic lines. It will draw most of its support from the left, both because of this expensive egalitarianism and because the religious right will blanch at the moral issues raised (though they're in some ways less troubling than those raised by amniocentesis and abortion).

The old eugenics, by its nature, could happen only if the government stepped in and orchestrated it. The new eugenics will start happening unless the government steps in and stops it. It is the political difficulty of stopping it—of saying no to that mother with the breast cancer gene—that will lead the government to accept and regulate it. A large amount of good can result from government involvement, as well as a large amount of creepiness.



'Dad, can I borrow the club tonight?'

THE SPECTATOR 28 January 1995

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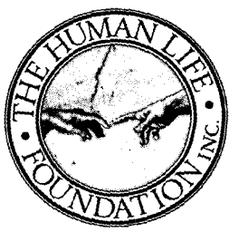
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