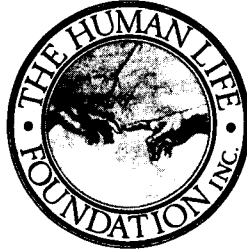


the HUMAN LIFE REVIEW



SUMMER 2002

Featured in this issue:

David S. Oderberg on . . . Why Abortion Isn't Important

David P. Mortimer on Negative Eugenics

Hadley Arkes on Unheralded Good

Mary Meehan on Recapturing the Joy of Life

Sherwin B. Nuland on The Principle of Hope

Lynette Burrows on "Older Children"

Also in this issue:

George W. Bush • Gilbert Meilaender • Elizabeth Fitton
Sidney Callahan • Lee Bockhorn • Mike Ervin • David van
Gend • David Davenport • J. Bottum • Wesley J. Smith

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ABOUT THIS ISSUE . . .

. . . alongside a steady stream of original articles, we continue to cull the universe for valuable work you may have missed elsewhere. Eagle-eyed readers have probably noticed a proliferation of articles plucked from various Internet websites. *National Review Online* (www.nationalreview.com) is a constant source of interesting and important material: we thank them for permission to reprint “Unheralded Good,” Hadley Arkes’ overview of the Born-Alive Infants Protection Act (p. 23); Elizabeth Fitton’s “We’ve Only Just Begun” (p. 83), and Wesley J. Smith’s “Doctors of Death” (p. 94).

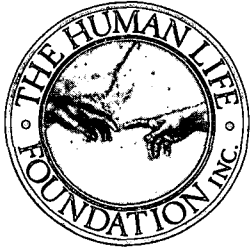
Lee Bockhorn’s “I Don’t Have A Choice” (p. 83) came via *The Standard Online* (theweeklystandard.com), a publication of the *Weekly Standard*. Thanks, as always, to our friends at the *Standard*, not only for the Bockhorn piece, but for letting us bring you recent articles published in the magazine by Gilbert Meilaender (p. 73), and J. Bottum (p. 91). Another magazine we’re thanking more and more often is *Commonweal*, this time for Sidney Callahan’s thoughtful contribution to the ongoing embryonic stem-cell/cloning debate (p. 81). Ditto the *New Republic*. While we (obviously) can’t countenance even the limited scenarios in which Dr. Sherwin Nuland would allow euthanasia, we heartily endorse the fine review (p. 45) he gave *The Case Against Assisted Suicide* by Kathleen Foley and Herbert Hendin, an important new book of essays that’s bound to shake up *that* debate.

Steven Ertelt is president of Women and Children First, “a non-profit organization that uses the boundless tools of the Internet to disseminate information about life issues to people worldwide” (see their website: www.womenandchildrenfirst.org). One “tool” in their kit is the Prolife Infonet (www.prolifeinfo.org), a free e-mail list that distributes news articles, press releases, editorials, etc. on a daily basis. Not long ago Mike Ervin’s “There’s No Such Thing As Mercy Killing” (p. 85) was part of the mix. Thanks to Mr. Ertelt for the important work his organization is doing in giving voices like Mr. Ervin’s a cyber-platform to reach tens of thousands.

Returning to the “old” world of books, we’re pleased to include in this issue (p. 59) a chapter from our friend and contributor Lynette Burrow’s newly-revised *Good Children: A Commonsense Guide to Bringing Up Your Child*, out this fall from Family Publications. If you’d like to read more, copies may be ordered from Family Publications, 6a King Street, Oxford OX2 6DF, United Kingdom. Or take out your credit card and visit *their* website (www.familypublications.co.uk).

Finally, thanks to reader (and former HLR staffer) Elizabeth “Lizzie” DiPippo, who spotted David Davenport’s commentary “When Pro-choice Is No-choice” (p. 89) on, yes, the Internet, and e-mailed it along in case we’d missed it—we had, but now you won’t.

ANNE CONLON
MANAGING EDITOR



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INTRODUCTION

“ABORTION IS NOT important. I never thought I could write such a sentence.” We never thought we could print such a sentence either! And yet it is the title of Professor David Oderberg’s lead article for this issue.

Of course, he goes on to explain what he means by his shocking statement: abortion is only *one* manifestation of a much deeper illness in Western society. Oderberg argues persuasively that, in spite of his controversial title, fighting abortion is as crucial as ever, but he believes prolifers need to “spend more time” thinking about “bigger issues and how they relate to their primary concern.” A society that not only tolerates but embraces abortion as “the very solution to what ails” it is a society that is in a “state of utter desolation,” one that has gone seriously wrong, “long before the sixties, long before any of us was alive.”

Oderberg, who is a philosophy professor at the University of Reading, England, has given us a piercing analysis of prolife activists against the backdrop of today’s cultural realities: like it or not, he warns, it may not be *possible* to have rational debate with “modern moralists,” because of the extent of their moral corruption. Yet he advocates that we become even *more* obsessed with life and death, even in the face of what seems like insurmountable obstacles in the fight to restore protection to human life: for “it is not only on what we achieve (and we may achieve a lot in the short or medium term), but on what we defend that we will be judged.”

Our next article is further proof, unfortunately, that we are living in a society that sees abortion as a “solution.” David Mortimer, who is Legislative Program Coordinator of Americans United for Life, reports on the “pariah theory”: in May of 2001, researchers John J. Donohue III and Steven D. Levitt published a study in Harvard’s *Quarterly Journal of Economics*, titled “The Impact of Legalized Abortion on Crime.” Their thesis is simple: the killing of unwanted babies has resulted in a decrease in crime. The study argues “that the disproportionate abortion rates among teenagers, unmarried women, and African-Americans are directly linked to a tremendous drop in crime”; *Roe v. Wade*, the authors argue, may be saving the U.S. about \$30 billion annually. As Mortimer writes, “These academics are speaking America’s love language: taxpayer savings and greater safety for all.”

Except for the unfortunate babies of course, whose deaths might be seen as the bloody results of another social theory with a deadly track-record—eugenics, or even, in the case of African-American babies, ethnic cleansing. As Mortimer explains, the pariah theory is a prime, current-day example of “negative eugenics: the elimination or prevention of genetic threats or burdens to

society.” Although eugenics got a bad name from the Nazis, it never really went away: Mortimer reminds us of our own not-so-distant past, when, in the 30’s, the government forcibly sterilized “the unfit.” Though contemporary eugenics is not coercive, Mortimer warns that it is potentially even *more* dangerous—you’ll see why in this compelling piece by our welcome new contributor.

Despite the sobering realities reflected in these first two articles, there is some good news, albeit “unheralded,” in the fight to protect life. The popular press was *not* quick to report this, but, on July 18th, Congress passed the Born-Alive Infants Protection Act. Professor Hadley Arkes, a chief architect of the legislation, wrote an essential guide to the Act—its history, the politics of its passage, and its significance—for *National Review Online*. We are pleased to reprint it, not only as a typically eloquent and clear-minded essay from our friend Prof. Arkes, but as an important chapter in the historical record of our movement. And we congratulate Arkes on his tireless crusade to push through this “spare—and truly momentous” bill. At the time Arkes wrote, President Bush had yet to sign the Act, and Arkes worries that the significance of the bill might be deeply marred if the President missed the chance to mark the bill’s signing with the right words. On August 5, President Bush did indeed sign H.R. 2175; we have reprinted his remarks as *Appendix A*. Professor Arkes is acknowledged as present, and we expect he was pleased with Bush’s words, which hailed the Act as a “step toward the day when every child is welcomed in life and protected in law.”

Next, we have a welcome detour into *joy*—specifically, Mary Meehan’s engaging new study about how we can “recapture the joy of life.” She begins by asking, “Why do so many people today view planned death as a good answer to personal and social problems?” She’s talking here not about the planned death of abortion, but of people orchestrating their *own* deaths, and she proposes a reason: an overwhelming problem we all face called “cultural depression.” “Our contemporary culture, for all its emphasis on entertainment and *fun*, produces unhappiness,” she claims.

Meehan offers sensible advice to combat this collective depression, and then focuses specifically on two groups of citizens who are especially hurt by our cultural malaise: the mentally disabled and the elderly. People disabled by mental illness are often doubly hurt because their handicaps are still feared and misunderstood by many, and, as Meehan explains, our current culture can exacerbate feelings of isolation. Yet there is encouraging new information about programs for the mentally ill, programs which stress that “one can recover and claim responsibility for one’s life without having to be fully cured” of a brain disorder. After reporting on approaches that work to help the mentally ill recapture joy and trust, Meehan moves on to the elderly, focusing on a major threat to their mental well-being—the fear of nursing homes and/or the homes themselves. Again, she lets us in on some wonderful new programs

that manifest a much greater sense of respect and inclusion for the elderly than is generally present in our society. I can't help but think of a point made by Professor Oderberg, that one of the first symptoms of the malignancy which is the anti-life movement was the loss of "respect and due deference" for the elderly, as well as the loss of our sense of communal obligations. Thankfully, Meehan is reporting on movements already underway to effect a change—giving, we'd say, the world-weary a much-needed glimmer of hope.

The *Review* does not generally publish book reviews, but we came across a review essay in the *New Republic* which we think is extraordinary. The book reviewed will be of great interest to *Review* readers: *The Case Against Assisted Suicide: For the Right to End-of-Life Care*. It's a collection of essays edited by Kathleen Foley, a physician at Memorial Sloan-Kettering Cancer Center, and Dr. Herbert Hendin, medical director of the American Foundation for Suicide Prevention—both prominent opponents of physician-assisted suicide. The author of the review, however, is *not*, which makes what he wrote all the more remarkable. Sherwin B. Nuland, a physician and author, admits that, while he is a "euthanasia proponent," this book has made him stop and rethink much of what he had believed. He commends the collection as presenting a "powerful indictment of physician-assisted suicide." Although he continues to support the "right" to die, he finds that the group of persons whom he thinks would *need* that right has been made considerably smaller, thanks to facts he's learned in this new book. And he seems to want to believe more: "Like the underlying theme of all medical care, the book's message is hope. It is a form of hope that will leave some readers—myself included—incompletely convinced; but it is a hope so well articulated . . . that this book will long stand as the definitive counter-argument to the wild-eyed Kevorkians and the impatient Hemlockers." One might say that Nuland is an example of a "modern moralist" who hasn't lost his ability to listen to reason, and we hope that he will continue to reason his way *all* the way over to the side of life!

Our final article is a bracing slap of common sense, delivered with the usual panache by our friend from overseas, Lynette Burrows. It is a chapter from the revised edition (due out this fall) of her book, *Good Children*, and it focuses on "Older Children"—specifically, the lies the "health" industry spoon-feeds them in the guise of sexual "education." We're back to Oderberg again—what kind of a society do we live in, where, in the name of freedom of sexual expression, "educators" knowingly promote condoms to teenagers as the "all-in-one protection against pregnancy and sexually transmitted disease"? Putting aside the matter of sexual morality, the facts are that condoms have at *least* a 20 percent failure rate, and that sexually-transmitted disease rates have been *soaring* in the teen population. So where is the public service campaign to let teens know that the *safest* sex is abstinence until marriage? Well, there *is* a campaign, but not from health officials. Burrows writes: "Fortunately for

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our survival as a society . . . there is a growing movement . . . they are young, enthusiastic, and they are the driving force behind the programmes of abstinence that are currently making such progress in the USA.” Burrows ends on an upbeat note, a wonderful defense of marriage—you’ll enjoy this chapter, which for all its disturbing statistics, has wit and cheer.

* * * * *

We begin our Appendices with President George W. Bush’s statement upon signing the Born-Alive Infants Protection Act, in which he praises the legislation for extending the “promise of life and liberty made at our founding . . . to the most vulnerable members of our society.” His words also marked the Act as a step toward protection for the unborn, leaving no doubt where he stands on abortion: “. . . unborn children are members of the human family . . . they are created in God’s own image.” Bravo, Mr. President.

Meanwhile, as you know, when the President addressed the nation about his decision on stem-cell research in August 2001, he also announced the creation of a President’s Council on Bioethics, to be headed by Dr. Leon Kass. We publish as *Appendix B* an essay by one of the members of the council, whose work we have long admired, Gilbert Meilaender. (This particular piece, which appeared in the *Weekly Standard*, represents Meilaender’s own views and not those of the Council—we will have much more on the Council and its recent report in a future issue.) Meilaender’s subject is the so-called “compromise position” on embryonic stem-cell research, at least where federal funding is concerned: that research be done on “spare embryos,” left over from infertility treatments, while disallowing the actual creation of embryos solely for research purposes. While Meilaender says this position “is not without appeal, and it has a distinguished pedigree,” he soon makes it perfectly clear how completely unethical it is, and yet he does so in a non-accusatory way . . . this is an essay we wish everyone who has thought about this controversial issue would read.

The passing of the Born-Alive Infants Protection Act is a bright spot in a movement that has suffered so many staggering blows; we’ve plunged right into some of the worst-imagined scenarios of the slippery slope. In *Appendix C*, Elizabeth Fitton, assistant to the editor of *National Review*, writes a moving reflection on the prolife movement, prompted by the occasion of a dinner honoring her mother (Margaret Fitton, mother of 10!) for many years of anti-abortion activism. In “We’ve Only Just Begun,” Fitton writes: “Thirty years’ worth of struggle was represented at that dinner. I don’t know if I felt invigorated, or just discouraged, by hearing about all that they did and sacrificed—even while realizing what new and still more convoluted battles today’s pro-lifers face.” One of these struggles is convincing even some “prolifers” that human embryos need protection. So writes Sidney Callahan in an eloquent

Commonweal column that caught our eye for its original approach and breathtakingly simple logic. Here's a favorite passage: "But why is size an issue when there is so much inherent developmental capacity? Surely size in a world of quarks, quantum events, and neutrinos is relative. In the microrealm a zygote and blastocyst can appear pretty gigantic."

As with Meilaender, we wish everyone would read Callahan. Sadly, *Commonweal* has many fewer readers than the *New York Times Sunday Magazine*, which, in two consecutive "Lives" columns, published culture-of-death puff pieces masquerading as reflective analyses on "hard choices." The first (7/7/02), about an unwed mother-to-be given *no* choice, is masterfully dissected in *Appendix E* by Lee Bockhorn of the *Weekly Standard*. The following Sunday's "Lives" column, "Survivor," was written by "James Scott, as told to Paige Williams," and carried this subtitle: "After years of watching them suffer, his mother shot his two brothers. Now he's the only one left." The three brothers were all victims of Huntington's disease, as was their (now-deceased) father. The *Times* uses them as a poster family for "mercy killing." In *Appendix F*, Michael Ervin writes about the murders, which *he* read about when the *Chicago Tribune* published a commentary defending the mother's actions. Ervin, who has muscular dystrophy, says "mercy killing" is in reality an expression of "profound contempt" for the disabled.

In another trenchant denial of "assisted" death, Dr. David van Gend writes in *Appendix G* about the case of Nancy Crick, a woman whose death was facilitated by Australia's "Dr. Death," Philip Nitschke (who Kathryn Jean Lopez profiled in our Fall, 2001 issue). In *Appendix H*, David Davenport reports on disturbing new legislation out of California which would mandate that California medical schools provide students with abortion training. Next, the *Weekly Standard*'s J. Bottum reports that the press reaction to the Bush Administration's decision *not* to fund the United Nations' population-control apparatus was "apoplectic You'd think from all this that President Bush had declared war on half the globe"—instead of taking a stand against UNFPA's support of China's population program, which includes coerced abortions.

Last, but in no way least, in *Appendix J* we have our esteemed colleague and *Review* contributor Wesley J. Smith writing about a reason for opposing physician-assisted suicide that resonates even with liberals: HMO's—"Liberals hate HMO's." He reveals the disturbing contents of a recent memo from a major HMO to its doctors, in which participating in assisted suicide is actually *solicited*—after all, it is a less costly method of "taking care" of patients!

Rather than end on a distressing note, we remind you that laughter is famous for its restorative powers, which is why we again include choice cartoons from our clever friend, Nick Downes. We wish you good reading.

MARIA MCFADDEN
EDITOR

Why Abortion Isn't Important

David S. Oderberg

Abortion is not important. I never thought I could write such a sentence. In fact, I never thought I could think it. But I do. That's not all. I also think that euthanasia is not important. Nor cloning. Nor contraception. Nor IVF, embryo experimentation, genetic engineering, nor any other issue at the core of pro-life activity and policy. In fact, pro-life activity and policy themselves are not important. However, before you write a letter of outrage to the editor, or tear up your subscription, allow me to explain.

To clarify what I mean by these issues' not being important, let me point out that I am not saying for a minute that pro-lifers should stop being pro-lifers, that we should spend our afternoons tending our rose bushes rather than campaigning, protesting, writing, or whatever it is that we do best in defending the pro-life cause. Like most pro-lifers, I am opposed to every single one of the things listed above. Every one of them is a moral crime, an attack on the sanctity of human life, and every one of them should be opposed in heart and mind and action by all people of good will. And yet—they are not important.

As a professional philosopher, I am trained to look at the big picture. True, most of my fellow philosophers, at least in the Anglophone academies, have pretty much given up on big pictures. We philosophers hardly ever talk about big pictures at our end-of-term garden parties, or in the common room between lectures. We don't knock on each other's doors and say, "Hey, Fred, what do you think of the state of Western civilization?" It's just not done. What is done is to knock on a colleague's door and say, "Hey, Fred, what do you think about Quine's denial of the analytic/synthetic distinction? Don't you think recent theories of meaning have cast doubt on his critique?"

Don't get me wrong. Quine's denial of the analytic/synthetic distinction is important and well worth debating. Plenty of good papers have been published on it. My list of things to research in philosophy would be a lot shorter if I didn't have subtle or not-so-subtle technical distinctions to analyse. It was good enough for Aristotle and St Thomas Aquinas (let alone all the other great figures in the history of my subject)—so it's good enough for me. Yet through it all, through the endless training in technicalities, and even despite the best efforts of many of those who taught me to philosophise, I have, one

David S. Oderberg is Reader in Philosophy at the University of Reading, and a previous contributor to the *Review*. His most recent books are *Moral Theory* and *Applied Ethics* (Blackwell, 2000).

way or another, been trained to look at the big picture.

Which is why I have come more and more to see that pro-life issues, including the ones on which I have published at length and will continue to publish, form a smaller component of the overall stance that should be taken against society than many pro-lifers would think. Social activism, like everything else in the marketplace of goods and ideas, inevitably involves a division of labour. Animal rights campaigners (for all the bad mixed in with their good intentions) campaign for animals and very little else; animals are their world, the abolition of the battery cage their *raison d'être*. Campaigners against paedophilia have the welfare of children as their sole social concern, and see social policy through the prism of their anxiety that children be protected at all costs. Anti-globalists interpret every facet of economic policy in terms of its promotion or reduction of the depredations of transnational big business.

Pro-lifers are no exception. Of course I exaggerate, but the basic point is correct, that when a person embarks on the defence of a cause (and why they pick one cause rather than another depends on all sorts of reasons both personal and political), they tend to focus exclusively on that cause and to see all other social issues primarily in terms of how those issues reflect upon it. The division of labour is a good and necessary thing, both in economics and in social activism. I am certainly not advocating the disappearance of single-issue campaigning, or of multi-issue campaigning (like pro-life activism) that revolves around one large chunk of social policy. No policy would ever change if activists regularly spread their campaigning too thinly, thus depleting their intellectual and emotional (not to mention financial) resources beyond their usefulness in any one specialized operation.

What I am advocating, however, is that pro-lifers as a whole spend more time thinking about bigger issues and how they relate to their primary concern to protect innocent human life from womb to tomb. Perhaps the single thing that contributed most to this realization was when I first read the famous paper published in 1958 by the eminent (and recently departed) Cambridge philosopher Elizabeth Anscombe. Writing about the utilitarianism that has, since Bentham and Mill, taken over virtually all moral theorising in the English-speaking departments of philosophy (perhaps less true today of high-level moral theory than of applied ethics, where of course the damage is really done—witness Singer and Co.), Professor Anscombe noted that it had become a serious topic of moral debate among philosophers whether it could ever be justified to kill an innocent man (e.g., to save five others). Her response was brave—brave because it went so contrary to the grain of philosophy as

argument and dialectic. What she said (and here I paraphrase and interpret¹) was that when confronted with a person who really thinks it a live moral issue whether killing the innocent might ever be justifiable, even if that person offers sophisticated utilitarian arguments in support, the right thing to do is to walk away rather than argue; for such a person shows evidence of a corrupt mind.

Here is one of the (to my mind) greatest philosophers produced by England in the last century, telling people—especially *other philosophers*—that sometimes it is better to walk away than to argue. Why? Because a person's conscience can become so corrupt, and lead to such equally corrupt rationalizations, that to engage them in serious argument about those rationalizations is both pointless—being unlikely to have the slightest impact on their thinking—and, what is worse, dangerous—bringing the thinker of good will into serious danger of having his own conscience perverted by the sophistries of the other.

Professor Anscombe did, nevertheless, write much in defence of life—though, notably, much of it for those who already valued life, arming them with arguments, rather than for those who could not even see the truth of the conclusions the arguments were arguments for. As to activism, well, it is not often that one sees a picture of an eighty-year-old female academic lying on the ground being dragged off by the police to the local lock-up. Her crime? Protesting outside an abortuary, of course.

Had she decided that protest against the devaluers of life was more rational than engaging them in argument over the futility of utilitarian thinking? I never got the chance to ask her, but the remarks in her 1958 paper gave pause for thought. After all, thousands of philosophers across the Western world (and it is the West with which I am solely concerned) continue to pose the very sorts of question Anscombe derided as showing evidence of moral corruption. Killing the innocent? No, that's no longer even a question—most philosophers do not have a problem with it. Rather, it's meatier territory they stake out now. In fact, when I first learned that the *Doctor Exsecrabilis* Peter Singer was now somewhat of a fan of bestiality,² I caught myself being not nearly as surprised as I thought I might be: surely this was the logical working out (by a thinker who satisfies G. K. Chesterton's definition of a maniac—not someone who has lost his reason, but someone who has lost everything *but* his reason) of a moral position that had already been poisoned decades ago by those first thoughts about whether morality is all about costs and benefits, and whether the job of modern moralists was to overthrow tradition and replace it with a brand new morality for our brand new times.

I assume it will be paedophilia next. Or perhaps incest. (Only a few weeks

ago I happened to listen on BBC radio to a learned discussion of incest [not involving Singer] that was as remarkable for its high seriousness as for the insouciance of its participants.) I ask pro-lifers: can we really expect to have a rational debate with these custodians of what's left of our cultural norms? Perhaps we should keep trying, lest there be one single person out there who changes his mind because of what pro-lifers have to say. Nevertheless, we also play right into the hands of the modern moralists when we approach ethical debate with such a narrow focus. What happens when a pro-lifer publicly debates, say, the so-called "morning-after pill" (alias the early abortion pill) with one of its advocates? Usually, the pro-lifer is accused of an unhealthy obsession with what goes on in people's bedrooms. Why all this fixation on sex? they want to know. Is it the usual "Catholic guilt" thing, or the fact that they want to deny to others what they secretly wish they could have for themselves? Why don't they get out of other people's private lives and worry about their own?

Of course, none of these responses is remotely rational. But the point is that listeners to such debates usually take the rhetorical bait, having long ago abandoned any pretence at rational thought about the issues themselves. And so pro-lifers are portrayed all too often as swivel-eyed, obsessive single-issue fanatics. Needless to say, the double standards are obvious, since such epithets are rarely applied to animal liberationists or anti-globalists. The pro-lifers always get the worst of it: partly due to the obsessions of their opponents, who are really the ones who are utterly fixated on all things carnal; partly through a genuine fear that pro-lifers still (more so in the USA than the UK, by far) have political clout and can actually change things, at least by clogging the courts and slowing down the passage of anti-life measures, at most by getting their own measures adopted (e.g. anti-euthanasia legislation). Partly, as well, due to a tiny trace of residual moral conscience left in their critics. But partly also, it must be said, to the pro-lifers' own excessively narrow focus.

Does that mean I advocate that pro-lifers should *stop* being obsessed by matters affecting the sanctity of life? Of course not. If we are not obsessed by life and death, we might as well not be obsessed by anything. What I *do* advocate, however, is that pro-lifers *increase* their obsession—not just with life matters, but with the whole state of Western society. We need to be obsessed by the state of utter desolation into which Western society is throwing itself. It may well be (as I believe) that what is left of Western civilization is doomed to extinction—but doing and caring nothing about it is just not an option. It is not only on what we achieve (and we may achieve a lot in the

short or medium term), but on what we defend that we will be judged. And we must come to the realization that when a society has reached a state in which abortion and other attacks on life are not only tolerated; not only legalized; not only accepted as normal; but are positively *embraced* by millions of people as the very solution to what ails that society—then we must realize that something has not only gone seriously wrong, but went wrong a long time ago, long before the Sixties, long before any of us was alive.

We do not need to become social or cultural historians to analyse the current state of things. We should also acknowledge that there is a feedback loop among the phenomena under discussion: explanation is not always in the one direction. A general state of slow-burning moral disintegration gave rise to the climate in which the Cultural Revolution of the 1960s could take place; but equally, with that revolution now secure and its ageing vanguard installed as our rulers, the revolution feeds back into the wider state of decay and gives it added momentum. Which way the explanation should go in a given case is best left to the historians. What is more important is that we need instead to see that actions such as abortion can only ever become the norm in a society in which the very bonds that tie us together as human beings have been torn apart. We need to understand that the anti-life movement is a secondary cancer, a metastasis of a primary tumour that began to grow when the West began to lose its religious sensibilities, its sense of communal obligation, its norms of respect and due deference for the elderly, the wise, the experienced, those who govern in our name, its standards of gentility and politeness, when people began twistedly to interpret manners as hypocrisy, *noblesse oblige* as exploitation, civic duty as state oppression, state patronage as a human right, love of neighbour as poking one's nose into the business of others, hypocrisy as the greatest vice of all (to which I reply—better double standards than no standards), and proper autonomy as the right to do as one pleases.

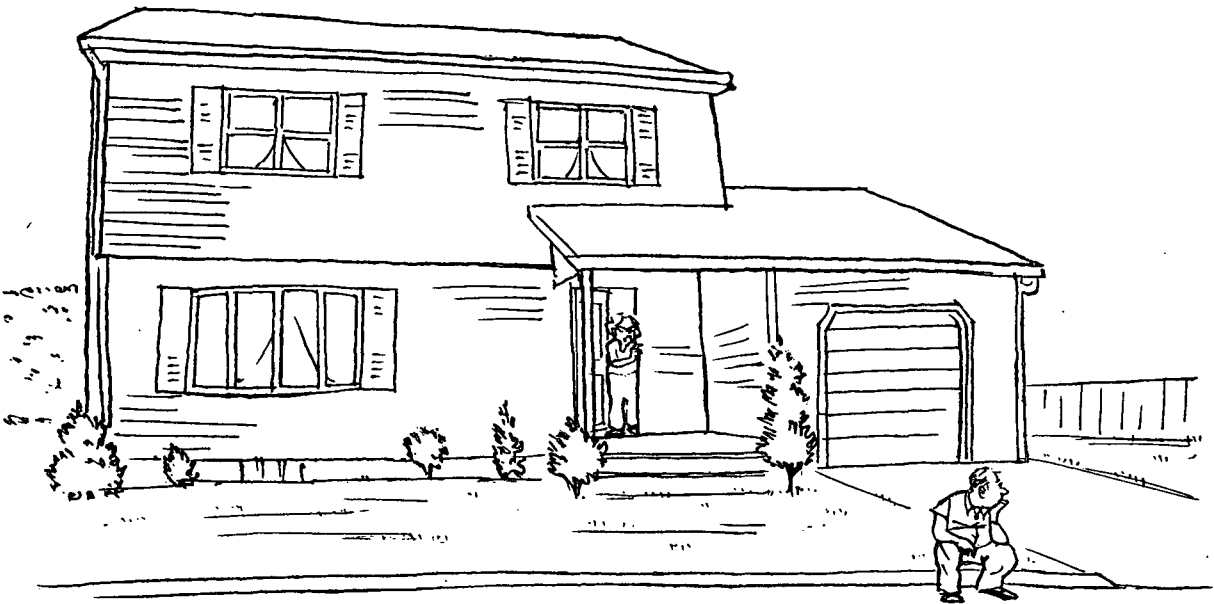
The primary cancer is as deep as it is old, and it is almost certainly terminal. But for us—as campaigners, writers, thinkers, activists—its terminal nature cannot be of prime concern. What we must attend to is the enrichment of our thinking about pro-life issues by studied consideration of just how the anti-life culture is rooted in a much broader social pathology. We need not, and must not, become self-styled experts on everything that is wrong with Western society (which of us can claim any such expertise?), and we must not dilute the pro-life message to the point where it no longer stands out against the cacophony of perpetual social commentary that clogs the exhausted airwaves

and ever diminishing magazines of “opinion.”

Still, pro-lifers must widen their perspective. We must understand the simple fact that a society in which people are judged not by their looks but by their virtues is a society in which *abortion would be impossible*. That a society in which travellers regularly give up their seats to the elderly is a society in which *euthanasia would be impossible*. That the antithesis of a me-first society in which physical perfection is the ultimate goal is a society in which genetic screening for physical handicap would be considered not as a moral outrage, but as just plain *absurd*—unthinkable, even. This is what I mean by saying that abortion is not important. A society which has gone as far as devaluing the lives of its own members has gone wrong long before. It is not just the metastases which must be attacked, but their malignant origin. Sure, let us be obsessed by anything that touches on life and death—how could we not? But let us also be obsessed by much, much more.

NOTES

1. To read her exact words, see ‘Modern Moral Philosophy’ in her collected papers entitled *Ethics, Religion and Politics: Philosophical Papers*, vol. III (Oxford: Blackwell, 1981), pp.26-42.
2. See his review of Midas Dekkers, *Dearest Pet: On Bestiality*, published on www.nerve.com in 2001 and also in the British magazine *Prospect* (April 2001).



“George, maybe the ice cream truck just isn’t coming today.”

The Posthumous Application of Negative Eugenics

David P. Mortimer

Halting and punishing crime in advance is risky, as John Anderton (played by Tom Cruise) learned in the Spielberg thriller “Minority Report.” Anderton, Chief of Washington, D.C.’s Pre-Crime Department in the year 2054, stops violent crimes before they are committed. With the aid of three pre-cognitive human beings networked and floating in nutrient liquid, a crime can be predicted, and a perpetrator identified with the aid of holographic computer imaging. The proto-offender is arrested and sentenced for the crime he or she never committed.

The Department is effective: There hasn’t been a murder in Washington, D.C. for six years, and its election year slogan is, “That which keeps us safe also keeps us free.” In this utopian world, citizens willingly trade their freedoms for guaranteed security. There are some skeptics, but Pre-Crime is viewed by most as a necessary evil. Although a few would-be perpetrators may suffer injustice, the whole city feels safe.

At first, Anderton is blind to the immorality of the precognitive technology he uses. Only after being accused of a pre-crime himself, and avoiding capture and retina scans by having his eyes illegally replaced, does he begin to see its great evil.

In our own day, crime rates have steadily plummeted for nine straight years, and risen only a few percentage points in the past two years.¹ Of the many possibilities to explain the dramatic decline, there is one startling theory that suggests criminals were eliminated before they had the chance to commit their crimes. It could easily be termed a “Pre-Crime theory,” but without the “pre-cogs,” holographic technology, and police arrests.

In May 2001, researchers John J. Donohue III and Steven D. Levitt came to the provocative conclusion that “[l]egalizing abortion in the early 1970s eliminated many of the potential criminals of the 1990s.”² Their study, “The Impact of Legalized Abortion on Crime,” was published in Harvard’s prestigious *Quarterly Journal of Economics* and its conclusion rests upon the premise that abortion is a remedy to the problem of unwanted children.

According to the study’s authors, the Supreme Court’s *Roe v. Wade* decision in 1973 legalizing abortion may be saving “on the order of \$30 billion annually.”³ These academics are speaking America’s love language: taxpayer

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savings and greater safety for all. And *Roe*'s "rebate check" does not even begin to reflect the billions in savings to the welfare system of not having to provide prenatal and postnatal care to mothers and children in poverty.

With detailed statistics and tables, Donahue and Levitt correlate the sheer number of American abortions with the dramatic drop in crime some eighteen years after *Roe v. Wade*. Referred to as a "pariah theory" in a *New York Times* headline, the study argues that the disproportionate abortion rates among teenagers, unmarried women, and African-Americans are directly linked to a tremendous drop in crime.⁴ These women, they argue, are more at risk of having children—pariahs—who would grow up to engage in criminal activity. With legalized abortion eliminating these bad apples, fewer criminals are around twenty years later to steal BMWs, slash their tires, or sell crack to their owners.⁵

The theory is based on a kind of statistical racial profiling: children born to disadvantaged women have "poor life prospects," tend to spend their childhood in poverty, and are "resented" and "unwanted." The authors cite studies that indicate many of these children grow up unloved and fatherless, and tend not to be held, breastfed, rocked or nurtured by their mothers. These factors place a young child at risk to become a habitual criminal or violent crime offender. In short: poor minority families are the seedbed of criminality.

Yet, Donohue and Levitt attempt to sidestep the issue of race by arguing that the most significant risk factor for criminal behavior is being "unwanted."⁶ With a formulaic $B < 0$ to indicate an unwanted baby, they argue it was the disproportionate elimination of *unwanted* fetuses that caused the unexpected windfall in reduced crime.⁷ The researchers have thus appropriated and recast the "every child a wanted child" slogan first used by eugenicist and birth control crusader Margaret Sanger (and fifty years later by abortion proponents).⁸

The most disturbing part of the Donohue-Levitt study is their contrast between states with the lowest and the states with the highest abortion rates. Some states may have missed out on the unforeseen benefit of reduced crime because their abortion rates were the lowest: Murders in these states increased by 16.9%. States with the *highest* abortion rates, however, saw murder rates plummet by 31.5%.⁹ The data suggests that no matter what other poverty programs are in place to assist the poor and reduce crime, the sheer number of abortions dwarfs all other factors.

Unwitting Eugenics

This is the familiar methodology of eugenics: In the interest of all, the elimination or prevention of genetic burdens and threats to society will reap considerable cost savings. Technically, this is known as "negative eugenics," in contrast to "positive eugenics" which seeks to match together those with

well-endowed heredity.¹⁰ In the eugenics of the 1920s and 1930s, many social problems were thought to be largely due to poor heredity. By contrast, the eugenics of today has largely abandoned the old nature/nurture debate, and cares little if societal burdens are due to heredity or environment. Because these human beings will self-perpetuate—due to ill heredity or environment (it matters not to social engineers)—their eugenic elimination or prevention is a necessary evil for the greater good of society.

Eugenics, from the Greek for “well born” (or “good heredity”), advances a hierarchy of human lives. A term coined by Francis Galton in 1883, eugenics began as a movement to create a superior form of humanity by creating the conditions that would encourage the reproduction of the “fit” while discouraging the “unfit.”¹¹ Galton, in his book *Hereditary Genius*, argued that human beings should take control of their own evolution using breeding techniques known to science. The eugenics movement “spread rapidly in the early years of the twentieth century among the cultural elite and the intelligentsia. . . .”¹² It was a blend of popular nineteenth century biological science and philosophy, and it appropriated the power of the state to achieve its end of improving the genetic shape of the populace. It was a powerful social movement before being momentarily discredited by the Nazis and totalitarianism. Regaining popular and academic support in recent decades with the rise of new medical technologies, its hierarchical and selective ideology has been permitted to return with new force and legitimacy.

Eugenics is utilitarian and rejects the concept of equal human moral worth. It always creates a class of outsiders, burdens—even enemies—of the body politic. On the top are those lives of greater value—lives worth expending resources upon—and on the bottom are those deemed unwanted, worthless, emotionally burdensome or costly. In eugenic criminology, those on the top should be protected from crime and undue financial burden, while those on the bottom tend to be perpetrators and costly ballast. (Perhaps recent corporate crimes involving Enron and WorldCom will help correct this thinking.)

It may not be known for years whether or not the Harvard “pariah theory’s” methodology is valid.¹³ But if Donohue and Levitt are correct, America has unwittingly embarked upon a government-sanctioned eugenics project that dwarfs any ethnic cleansing in Eastern Europe. The missing cohort since January 1973 is now 40 million. By dusting off the old eugenic model of reducing crime and poverty by eliminating would-be criminals and the impoverished, these academics have brought statistical support to the legal holding of *Roe v. Wade*.

Ominously, the “pariah theory” has all the benefits that once evaded the pseudoscientific and racist eugenics movement. In Europe and America, the power of the state was used to prevent, segregate, sterilize, or eliminate those

deemed “unfit.” The legislature was the most expedient vehicle for its program. States enacted laws to “protect the class of socially inadequate citizens . . . from themselves” in an effort to “promote the welfare of society by mitigating race degeneracy and raising the average standard of intelligence . . .”¹⁴ Not only crime, but pauperism, feeble-mindedness, insanity, idiocy, imbecility, and epilepsy were thought to be hereditary. Such institutionalized people were, in the words of the Virginia Sterilization Act of 1924, “by the propagation of their kind a menace to society.”¹⁵ By the mid 1930s, over half of the states had eugenic sterilization laws on their books, and over 20,000 legal sterilizations had been performed.¹⁶

By contrast, contemporary eugenics uses the power of the state, *but is uncoercive*. It has adapted itself to embrace some of the ideals of a free society and has enveloped itself in a legal theory of rights, choice, freedom, and privacy.¹⁷ Rather than being legislated, its agenda is permitted by the rule of law (i.e. the expansion of rights). The primary branch of government to expand its agenda is no longer the legislature (as it was with the eugenics of nearly a century ago), but the judiciary. Its greatest cultural artifact in law is the “mystery passage” in *Planned Parenthood v. Casey* (1992):

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.¹⁸

The unencumbered autonomous self defines his/her own reality. In so doing, the traditional relationships between mother and offspring, parent and parent, and parents and offspring (as well as family) are redefined. Judge Robert Bork commented that this “fog-bound rhetoric” describes a “mood of radical individualism,” and it is no wonder why the struggle for control of judgeships has become savage and political.¹⁹ When coupled with the program of eugenics, the state is able to accomplish selective population control (perhaps weeding out criminals or the unemployable) through free choice and incentives. The strategy is simply to legalize and subsidize.

While there is little fear that we will soon return to the legislative coercion of the old eugenics, there is a far greater worry: the eugenic hierarchy of human lives together with the mood of radical individualism will increase pressure on the judiciary to continue its expansion of individual rights. Penumbrae and emanations will benefit those who are fortunate to be

well-placed on the hierarchy, but those who are victims of poor heredity or unfortunate environment will be left out (losers include the medically dependent, the aged, and the handicapped newborn). Eugenics has a history of demonizing the poor and exaggerating their pathology.

An astonishing example of this eugenic reasoning is found in 1927. Supreme Court Justice Oliver Wendell Holmes wrote the majority opinion in *Buck v. Bell* upholding the coercive sterilization of Carrie Buck, a ward of the state who was determined to be “feeble minded.” (the vote was 8 to 1): “It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.” Holmes reasoned that if the government can ask its “best” people to give up their lives for their country in war, it could ask those “least fit” to lay down their procreative powers for the greater benefit of society.

This popular eugenic sentiment was shared a few years earlier by Margaret Sanger in a chapter entitled “The Cruelty of Charity” in her book, *The Pivot of Civilization*.

Those least fit to carry on the race are increasing most rapidly . . . Many of the children thus begotten are diseased or feeble-minded: many become criminals. The burden of supporting these unwanted types has to be borne by the healthy elements of the nation. Funds that should be used to raise the standard of our civilization are diverted to the maintenance of those who should never have been born.²⁰

Sanger bristled at the charity provided by churches for the poor, considering such work to have a dysgenic effect upon the population by multiplying “bad stocks.”

In addition to creating a hierarchy of human life, eugenics considers traditional charity to be cruel, a Malthusian argument that would see the necessity of fetid pools and the plague as a necessary check on population, or a Darwinian perspective that views nature “red in tooth and claw” as improving life for all by the elimination of the weak and unfit.

Academia and Eugenics

Ironically, it was Donohue’s Stanford University and Levitt’s University of Chicago (along with Harvard, the institution that published their peer-reviewed study), that first gave birth to the eugenics movement in the United States.²¹ It began with the formation in 1906 of a blue ribbon Committee on Eugenics of the agricultural American Breeders’ Association. Members included the Chancellor of Stanford University, a University of Chicago sociologist and expert on crime, a Stanford biologist, and a Harvard geneticist.²² The purpose of the committee was to “investigate and report on heredity in

the human race” and “to emphasize the value of superior blood and the menace to society of inferior blood.”²³ A few years later a sub-committee on criminality was created which included Charles R. Henderson, a University of Chicago sociologist.²⁴ The most prominent leader on the Eugenics committee was Charles B. Davenport (previously an instructor at Harvard University and the University of Chicago), who would become a central figure in the eugenics movement. A movement advocating a hierarchy of humanity, eugenic research was spearheaded by academics at these, and other, Ivy League institutions.

The inevitable conclusion of the Donohue-Levitt study is that abortion is a legal choice and a necessary evil. The true quality of the “choice” involved is never discussed (the reality is that a woman often perceives she has “no other choice,” or a “choice” under pressure from a boyfriend, friend, a spouse, or parents). Yet, with these researchers’ findings, low-income women may now contemplate the elimination of their offspring as a patriotic good—a heroic self-sacrifice to benefit society’s greater safety and well-being.

The researchers attempt to avoid discussions of public policy, and in interviews Levitt maintains his work “is not proscriptive, but descriptive.”²⁵ The lines blur, however, when the subject of the Hyde Amendment comes up. A law enacted by Congress in 1976, it prevented tax dollars from being used to fund Medicaid abortions. In Donohue and Levitt’s study the law receives restrained scrutiny. Yet, the inevitable signal to politicians is that any abortion disincentive that would discourage poor minority women from abortions would be wrongheaded, counterproductive, and excessively expensive to taxpayers decades later. The study lays the foundation for the argument which will someday be heard in state and federal legislative hearing rooms: In order to reap the maximum benefit of reduced crime, the government must not only legalize abortion, it must subsidize it.

In their first working paper, Donohue and Levitt conclude their summary with mention of the estimated \$30 billion saved annually as a result of abortion. In estimating the possibility of a *continued* 1-2% decline in crime over the coming decades, their paper concludes with a final sentence: “To the extent that the Hyde amendment effectively restricted access to abortion [of poor women], however, this prediction *might be overly optimistic*.”²⁶ In this early draft, the researchers could hardly refrain from political comment, and the message of the statistics is clear: if abortion is not subsidized for the poor by government or private means, society will pay by suffering more crime.

In the same working paper, other studies are cited that estimate the increase of “unabortions”—unwanted births due to federal bans on Medicaid abortion funding. Then Donohue and Levitt suggest that “the crime-reducing ef-

fect of legal abortion . . . *may be dampened* as a result of the ensuing restrictions in public funding of abortions.”²⁷ Their final peer-reviewed study is more cautious. In their discussion of the Hyde Amendment as a factor in making abortions less affordable, they conclude indifferently that “most recent research suggests any impact [of the Hyde Amendment on births and abortions] is small.”²⁸ Perhaps this final assessment was a safe compromise by the researcher to minimize the expected firestorm after publication, and allow others to connect the dots and draw the obvious conclusions.

Possible Applications of the “Pariah Theory”

The application of Donohue and Levitt’s findings have much to do with incentives. How might abortion be made affordable and accessible to the at-risk single minority mother? Claiming their research is apolitical, Levitt commented that in the economic worldview of their research, “people respond to incentives.”²⁹ Although not discussed in their study, it is important to consider the “pariah theory’s” likely applications:

- additional government-subsidized Planned Parenthood abortion clinics in poor neighborhoods to ensure that crime rates continue to drop;
- more permissive abortion laws at the expense of women’s health and their right to know the risks (physical and psychological) of having an abortion;
- increased funding of Medicaid abortions (a \$400 Medicaid abortion of a likely proto-criminal is a much cheaper one-time expense than the annual cost of over \$20,000 to keep him in prison); and
- abortions for “high-risk” mothers in exchange for welfare benefits (some cities pay at-risk drug abusers to undergo sterilization, so why not offer abortion incentives to welfare recipients?);
- prenatal testing to identify and eliminate through incentives fetuses with a higher genetic risk for violence (such as fetuses with predictors such as the low-activity MAOA gene that may be activated by maltreatment while growing up).³⁰

Sometimes the lines between incentive and coercion blur. Although these examples may sound extreme by today’s standards, a May 2001 Zogby poll found that almost two-thirds of Americans favored legislating mandatory birth control for all welfare recipients.³¹ This attitude toward welfare mothers is not new in America.

In addition to these possible applications, one should expect to see more academic research following the trail blazed by Donohue and Levitt. These new and more bold studies will likely describe themselves as “descriptive” rather than “prescriptive.” They will reiterate the myth that abortion is a necessary evil. Watch for:

- population studies attempting to calculate money that has been saved

by eliminating (through abortion) a huge cohort from the welfare rolls

- cost-benefit-analysis studies that measure the financial cost to society when legislatures cut public funding for Medicaid abortions; and
- studies to measure the decline in mental illness and other handicaps that are detected through routine prenatal testing (these studies will also estimate cost savings to society for institutional care).³²

Saving Compassionate Social Programs

Addressing poverty issues is a humanitarian solution to the plight of babies raised in conditions that may contribute to their later delinquency. The elimination of poverty, rather than a child, is always a more compassionate goal. Donohue and Levitt point out that they value the traditional anti-poverty solutions to address the environmental factors that seem to cause criminal behavior. However, these solutions are expensive and long-term. Their success is difficult to measure. The “pariah theory” indicates that a program of legalizing and subsidizing abortion is far more cost effective in reducing crime than any other program. If politicians begin to believe legalized abortion is responsible for the lion’s share of reduced crime, more vigilant efforts may be needed in the future to protect the budgets of more costly traditional social programs that reduce crime. The “pariah theory” puts at risk such costly programs as: adoption, parental training, early intervention programs, prenatal care, GED education, health care, daycare, TANF, CEDA, and unemployment assistance. These are examples of programs that would be expected of a developed country with a high income economy, while eugenic elimination is a policy one would expect to find in a totalitarian regime.

The problem of unwanted children is not new. Nearly 300 years ago Jonathan Swift anonymously presented a commonsense solution to the intractable problems of Irish hunger, poverty, crime, and “unwantedness.” In his pamphlet *A Modest Proposal*, he suggested that a fourth of the younger children be fattened and sold in the market for food. Such a policy would solve the problem of unwanted children. Every child—even the illegitimate—would be a wanted child, with all the value and advantage of a prized head of livestock. Crime would plummet. Hunger and overpopulation would end. The stagnant economy would prosper. Free choice, market forces, and elimination could turn the problem into a profitable solution for the greater good.³³ His satire, of course, dramatized the need for real choices and real opportunities, rather than the tendency to treat the poor as pariahs.

The applications of Donohue and Levitt’s “pariah theory” sound like economic—or perhaps ethnic—cleansing. This has always been the trouble with using science and economics to justify euthanasia (better off dead) or

eugenics (better off never born): the words “meaning,” “purpose,” “goodness,” “importance,” and “truth” are not in their lexicon. Lacking this vocabulary, neither science nor the market can be exclusive guides in public policy. Like the anonymous visionary in *A Modest Proposal*, their utilitarianism reduces human beings to livestock and their empiricism results in reforms like the Nuremberg Laws.

As the F.B.I. protagonist notes in the film, “Minority Report,” “It’s not the future if you stop it.” Growing up in difficult circumstances is an indicator—not a determiner—of criminal behavior. Eugenics deals with cohorts and populations and overlooks people. It treats some humans as weeds that threaten the garden. It promises easy results with little cost and creates a hierarchy of humanity. But like Pre-Crime, and the historical dustbin of all social control, utopia (from its Greek derivative) is “a place that is no place.”³⁴

NOTES

1. Christopher Newton, “FBI report shows rise in major crime,” *Chicago Sun-Times*, June 24, 2002, p. 25.
2. John J. Donohue III and Steven D. Levitt, “The Impact of Legalized Abortion on Crime,” *The Quarterly Journal of Economics* (May 2001), Vol. 116, Issue 2: 379-420. Donahue and Levitt’s study can be found at http://mitpress.mit.edu/journals/pdf/qjec_116_02_379_0.pdf
3. Donahue and Levitt, 414.
4. Alexander Stille, “Abortion Affects Crime Rates? Pariah Theory Now Considered,” *New York Times*, April 17, 2001.
5. Newspapers seemed to find it difficult to find an appropriate headline without sounding crass. The *San Francisco Chronicle*’s headline was “Crime-stopper,” (June 17, 2001, p. D1). Columnists had a field day, with Norah Vincent’s Village Voice column titled “Fewer Fetuses, Fewer Felonies?” (June 12, 2001) or Kathryn Jean Lopez’s *National Review Online* article “The Other Death Penalty” (June 19, 2001).
6. A newspaper teaser on their early research summarized: “Unwanted children are key.” Karen Brandon, “Abortion, reduced crime linked,” *Chicago Tribune*, August 8, 1999 p. 12 (the story ran on page one).
7. John J. Donohue III and Steven D. Levitt, “Legalized Abortion and Crime,” Working Paper No. 1 (6/24/99), p. 14. The study’s research argues that other factors that reduce crime have a minimal impact (although other researchers suggest the study overstates the impact of abortion and downplays factors such as a booming economy, rising incarceration rates, better policing, gun control, the end of the crack epidemic, the deterrence of tougher sentences, and greater use of alarms and guards).
8. In *Roe*, Justice Blackmun acknowledged “unwantedness” as a significant factor in a crisis pregnancy: “There is also the distress, for all concerned, associated with the *unwanted* child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it.” *Roe v. Wade*, 410 U.S. 153 (1973).
9. Before Donohue and Levitt’s final peer-reviewed study was even finished, this trend was graphically represented from their working paper in a side bar to a short article by Stacy Perman, “The Unforeseen Effect of Abortion,” *Time*, August 23, 1999, p. 47. It further shows that states with the lowest abortion rate had an increase of violent crime of 32.2% and an increase in property crime by 12.5%. In states with the highest abortion rate, violent crime dropped 1.7% and property crime dropped 24.3%.
10. In the first decades of the twentieth century in the United States, eugenic science was applied in two ways: through “positive eugenics,” a program of encouraging marriages between “fit” couples to produce “fitter families” with many children. While “positive eugenics” used persuasion, “negative eugenics” used coercion and was based upon the assumption that the genetically

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inferior were a threat to the state and therefore the state had to act in order to protect society as a whole.

11. For online primary documents and introductory essays, see the Dolan DNA Learning Center's "Eugenics Archive" funded by the National Human Genome Research Institute at <http://www.eugenicsarchive.org>
12. Wesley Smith, *Culture of Death: The Assault on Medical Ethics in America* (San Francisco: Encounter Books, 2000), 35.
13. The hypothesis that there is a correlation between being unwanted and growing up to have criminalistic tendencies is historically untrue. Presumably there were fewer "wanted" children born during the Great Depression, yet there was no correlative a blight of crime in the 1950s.
14. The *Virginia Sterilization Act*, §394 (1924). This statute, passed by the legislature in March 1924, was upheld by the U.S. Supreme Court in *Buck v. Bell*, 274 U.S. 201 (1927).
15. The *Virginia Sterilization Act*, §394 (1924).
16. Donald K. Pickens, *Eugenics and the Progressives* (Vanderbilt University Press, 1968), 91.
17. *Griswold v. Connecticut* 381 U.S. 479 (1965) invalidated a state statute criminalizing the use of contraceptives with a constitutional "right of privacy" found in the penumbra of the Constitution's *Bill of Rights*. This right of privacy was later expanded in *Roe v. Wade* when the Court invalidated state statutes criminalizing abortion.
18. *Planned Parenthood v. Casey*, 505 U.S. 851 (1992) (internal citations omitted).
19. Robert H. Bork, "Adversary Jurisprudence," *The New Criterion*, May 2002, 14.
20. Margaret Sanger, *The Pivot of Civilization* (New York: Brentanos, 1922), p. 279.
21. According to Haller, it was the first to organize using the name "eugenics."
22. David Starr Jordan, Chancellor of Stanford University, was the Committee's chairman. Members also included Charles R. Henderson, a University of Chicago sociologist and expert on crime, Vernon L. Kellogg, a Stanford biologist, and William E. Castle, a Harvard geneticist.
23. Mark H. Haller, *Eugenics: Hereditarian Attitudes in American Thought* (New Jersey: Rutgers University Press, 1984), p. 62-3. Haller quotes from the ABA's *Proceedings*, II (1906).
24. Haller, 65.
25. Marguerite Holloway, "The Aborted Crime Wave?," *Scientific American* (December 1999), Vol. 281, Issue 6.
26. John J. Donohue III and Steven D. Levitt, "Legalized Abortion and Crime," Working Paper No. 1 (6/24/99), p. 36 (emphasis added).
27. *Ibid.*, p. 9. (emphasis added). In a footnote, the researchers suggest that when Congress ended Medicaid coverage of abortion for the District of Columbia in the period 1988-1993, one might predict "that crime would jump in D.C. in the years from 2006-2011."
28. Donohue and Levitt, "The Impact of Legalized Abortion on Crime," *The Quarterly Journal of Economics*, p. 385, note 7.
29. Sasha Abramsky, "Did *Roe v. Wade* abort crime?," *American Prospect*, No. 1 (January 1-15, 2001), p. 26.
30. Ronald Kotulak, "Genetic link to cycle of violence identified: Study adds fuel to debate about behavior genetics," *Chicago Tribune* August 2, 2002, p. 1. This news item reports on the findings by two University of Wisconsin researchers in behavioral genetics, on the enzyme monoamine oxidase A (MAOA). The findings were reported in the journal *Science*.
31. Zogby Poll released May 10, 2001 [www.zogby.com/news]. (Last accessed 5/23/01). "Majority would support birth control mandates for welfare recipients, new Zogby America survey finds." Fox News's Sean Hannity and Alan Colmes covered the poll on May 14, 2001 with guests Ann Coulter and Star Parker.
32. It is interesting to note that prominent Canadian abortion doctor Henry Morgentaler cited the Donohue-Levitt study as validation of his beliefs of thirty years ago when he predicted crime and mental illness would decline. See Henry Morgentaler, "Abortion Has Led to a Decrease in Crime," *Abortion: Opposing Viewpoints*, Mary E. Williams, ed. (San Diego: Greenhaven Press, 2002), p. 153. This is a reprint of Morgentaler's "Abortion and Violence," *The Humanist*, March/April 1999.
33. Jonathan Swift, *A Modest Proposal for Preventing the Children of poor People in Ireland, from being a Burden to their Parents or Country; and for making them beneficial to the Publick* (1729).
34. Thomas More, *Utopia* (1516).

Unheralded Good:

The Born-Alive Infants Protection Act

Hadley Arkes

You might not have heard the news, for the *Times* and *Post* and the networks have not thought it something useful for us to hear: But for the first time since *Roe v. Wade*, the Congress will have enacted, and a president will have signed, a bill that marks a limit to the “right to abortion.”

A little more than a week ago, on July 18, the Democrats in the Senate permitted the reading and the passage of the Born-Alive Infants Protection Act, an act that seeks to protect a child who *survives* an abortion. The Congress could have accomplished something comparable with the bill on partial-birth abortion. But Bill Clinton vetoed that bill, and the Supreme Court struck down the similar bills passed in the states. There is now a president who will sign the bill, and yet even Bill Clinton would have found it hard to veto a bill as simplified and modest as the Born-Alive Act. No one except the radical feminists in the National Abortion Rights Action League had the touch of madness to oppose this bill, for no one except a crazed zealot would profess any doubt about the “human” standing of the child at the point of birth. Not that the members of NARAL have any doubt on that score themselves. It is just that they are willing to assert, with radical firmness, the right of a woman to destroy the child in her womb as a matter solely of her own interest, and the triumph of her own will.

But the feminists at NARAL were also moved to passionate opposition because they understood this bill better than many of its supposed friends among the Republicans, for they understood its animating principle. As modest as it was, the bill planted premises that ran deeper than the bill on partial-birth abortion. Indeed, it could be said that, with this bill, the Congress now prepares an even firmer ground for revisiting the bill on partial-birth abortion and insisting that the courts take a sober second look. Judge Richard Posner had twitted the drafters of the bills on partial-birth abortion: Those laws had never claimed the authority to protect the child herself, and so, he asked, why would the state have any compelling interest merely in shifting the killing of the child from the birth canal back to the uterus? With the Born-Alive Act, the

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Congress fills in that missing step: The child marked for an abortion is recognized now as an entity that comes within the protection of the law. When Bill Clinton vetoed the bill on partial-birth abortion, his concern was entirely for the feelings and health of the pregnant woman. Somehow that other being, the one whose head was being punctured, and the brains sucked out, never came within his sight. For the law, and for Clinton, the child was not there; her interests simply didn't *count*.

The Born-Alive Act accomplished its work in the most delicate way, without any contrived theories of the Constitution. The drafters took their model from the Defense of Marriage Act of 1996: Congress surely has the authority to pronounce on the meaning of terms in the federal code, which Congress, and only Congress, can legislate. Congress could then stipulate that by a "marriage" it meant a legal union of a man and woman, known as "husband" and "wife." In the case now of the child who survived an abortion, the Congress simply stipulated that the term "person," used in the federal code, and in federal regulations, "shall include every infant member of the species homo sapiens who is born alive at any stage of development." And the meaning of "born alive," set forth in terms to guide lawyers and judges, clearly encompasses "the expulsion or extraction [of a child] as a result of natural or induced labor, cesarean section, or *induced abortion*" (*italics added*).

And that is all. The bill is spare—and truly momentous. For it provides a predicate that can be built into the foundation now of every subsequent act of legislation touching the matter of abortion: that the child marked for abortion is indeed a "person" who comes within the protection of the law. The irony, though, is that this bill could be enacted only on terms that barred its sponsors from proclaiming, or even explaining, the things that made it such a landmark. Once the control of the Senate shifted to the Democrats, the bill had little chance of being introduced, even though it commanded wide support in both parties. The initiative, and the moral conviction, came from the House, from Charles Canady, the former chairman of the Subcommittee on the Constitution, and his successor, Steve Chabot of Ohio. Congressman Jerry Nadler (D, N.Y.) had the wit to see that the Democrats would embarrass themselves by voting against the bill, even though Nadler could not restrain himself, at every turn, from denouncing the bill, and the Democrats in the House and Senate clearly hated it. The Democratic strategy was just to go along—to avoid embarrassing themselves by voicing their opposition, and by giving the pro-lifers the argument that they evidently wanted. For that argument would only draw attention to the bill. By playing rope-a-dope in that way, the Democrats could snatch a victory of sorts from this political trap: The bill might pass, but

without the kind of debate that would establish the meaning, or significance, of the bill.

In need of meaning

The price of passing the bill in the Senate was essentially to give the Democrats what they wanted. The bill was introduced for its formal “readings” without explanation or fuss, by Harry Reid of Nevada, hardly a pro-lifer in anyone’s reckoning. In this style, the bill was “passed” late on a Thursday night, at the end of a cluttered legislative day, and just before the Senate would turn to a resolution honoring the musician and statesman Paderewski. Rick Santorum of Pennsylvania had introduced the measure last year, as a rider to the Patients Bill of Rights, and when he demanded a roll call, the vote was 98-0. But now there would be no roll call, and so no Democrat would be compelled to record a vote, either for or against. In fact, there were probably very few senators in the chamber when the bill was passed, in a perfunctory way, by a voice vote. Santorum would not be allowed to frame the bill, to point up its meaning, and no voice would be sounded to explain the significance of what was done.

And yet, the astonishing thing is that the Democratic leadership allowed the bill to come up at all and be passed, rather than buried until the end of the session. The seasoned watchers of Capitol Hill guess that the Democrats didn’t want the responsibility for killing a bill that seems sensible even to people who are “pro-choice” on abortion. In this construal, they might have reasoned that it was better to deprive the Republicans of the issue—they could clear the bill away briskly, as a measure that merits no discussion and bears no significance.

The real puzzle is why the Republicans were so willing to acquiesce in this scheme to help the Democrats escape from a political bind. In the Senate, Rick Santorum had little choice; the main cave-in came in the House, in the decision to remove the “findings” that would have made the premises of the bill explicit. Two years earlier, the attachment of those premises, spelled out, stirred a panic among the so-called Republican moderates, who threatened to join with the Democrats in adjourning the House. It stood to reason that if those premises were spelled out again, a large hunk of the Democrats could not have made themselves vote for the bill, regardless of anything Jerry Nadler had to say. The chairman of the Judiciary Committee in the House, James Sensenbrenner of Wisconsin, probably figured that he had enough trouble on his hands without igniting an explosion in the House. But a couple of years earlier, Charles Canady of Florida wondered why those “findings” would cause such political strain: Did the members really think that there was a

constituency for infanticide back in their districts? For the findings simply pointed out that it hardly made sense to vote for this bill unless one was implying that the child marked for an abortion, but born alive, has a claim to the protection of the law, and that claim cannot pivot on the question of whether anyone *wanted* her.

If that premise was not true, the Democrats were open to correct it: Do we protect the child because it pleases us to protect her—and would we cease to protect her when it ceased to please us? But if the child has a claim to the protection of the law, that must mean that the child has an intrinsic dignity, which cannot be contingent on her location, or on whether her existence serves the interest of anyone else.

In its immediate, practical effect, the bill was aimed to combat the judgment expressed 25 years ago, in *Floyd v. Anders*, by Judge Clement Haynsworth. A child had survived an abortion for 20 days, and when the question was put as to whether there had been an obligation to preserve its life, the answer tendered by Haynsworth was no. As he “explained,” that was not a child but a fetus, and “the fetus in this case was not a person whose life state law could protect.” In other words, the right to an abortion was the right to an “effective abortion” or a dead child. In its draft of the findings, the Subcommittee on the Constitution repudiated that very claim, for it had ample reason to think that Judge Haynsworth’s opinion was not an anomaly. Two years ago, a federal court struck down the bill on partial-birth abortion, with the opinion written by Judge Maryanne Trump Barry, the sister of Donald. Judge Barry treated with contempt the claim to protect the child at the point of birth, for the notion of “birth” she regarded now wholly as a matter of perception. And so she denied the premise that “the fetus is in the process of being ‘born’ at the time of its demise. It is not. A woman seeking an abortion is plainly not seeking to give birth.” This was postmodernist jurisprudence with a vengeance. There were no objective facts, only theories. Since a woman willed an abortion, there was no birth, and no baby there to be born. What Judge Barry’s opinion made chillingly clear was that Judge Haynsworth’s opinion, years ago, was not an aberration. His understanding was being installed right now, by many federal judges, as the reigning orthodoxy for the courts.

The “findings” would have helped in making these points, and conveying the significance of this bill. But even now there is a chance to salvage the situation, for even now the President could say something to mark, for the public, the meaning of the bill as he prepares to sign it. The president could strike a bipartisan posture to celebrate a collaboration of the parties: People of moderation of both parties have come together to affirm that, whatever else

the “right to abortion” means, it surely cannot mean the right to take the life of a child at birth. Every right has its limit, and with this modest step, both parties can establish that there is a limit to the right to abortion that even pro-choicers will acknowledge. At the same time, the parties will have established that Congress has the authority to legislate on this vexing subject. From the mass of 1.3 million lives taken in each year, we simply try to preserve at least a handful of lives. Who would find fault in that—and the president finds his strength, his own, strongest voice, in explaining just why we would save a handful of lives within our reach. If he does, the Democrats could hardly complain without courting the embarrassment that they have sought so capably to avoid.

The deep worry, of course, is that if nothing is said, the Democrats will have won. More than that, they will have finessed a remarkable victory from what figured to be, for them, a certain disaster. For who would attach any meaning to a law, when those who enacted it did not proclaim it, or even made some noticeable effort to impart its meaning to the public. In the absence of anything said officially, the meaning of the bill can be marked only in commentaries of the kind I have set down here. But such commentaries are as nothing, compared to the simplest words spoken by the president, for those words are spoken with the authority of his office and they have behind them the weight of the Executive branch. It is precisely at moments of this kind, with the moral questions thickening, that Mr. Bush has often shown his surest touch. My own hope is that he will redeem the efforts and the sacrifices made for this bill, and speak finally, at this moment, some telling words of his own.

Recapturing the Joy of Life

Mary Meehan

Why do so many people today view planned death as a good answer to personal and social problems? Why are they more interested in the mechanics of dying than the adventure of living?

Observers suggest that the culprits include nihilistic philosophy, the decline of religious belief, and the worship of autonomy. They note that population controllers make grim calculations that favor death. So do many people who worry about spiralling costs of medical care.

For people suffering from clinical depression or other severe mental illness, and for those facing possibly bleak years in a nursing home, death may seem to be a rational solution—although I will argue later in this essay that there is much we can do to help such people recapture the joy of life. There is, however, a more pervasive problem. It is that many people simply find little joy in life, so they do not understand its value to themselves or others. They are suffering from something that might be called cultural depression. “It is embarrassing,” Peggy Noonan has written, “to live in the most comfortable time in the history of man and not be happy.”¹ Our contemporary culture itself, for all its emphasis on entertainment and fun, produces unhappiness.

There is an old Southern expression: such-and-such “kills my soul.” If we determine what it is about our culture that kills our souls, we may find ways of helping people rediscover the value of life.

What Kills Our Souls?

While answers to this question are necessarily subjective, many people are likely to give the same ones. Many believe, for example, that electronic bombardment is out of control in our society. It is hard to escape the constant blabbering of television—not only in homes, but in stores, waiting rooms, airports, now even post offices. Television has become the babysitter for people of all ages, and not a kind or cheerful one, speaking unceasingly about murder and mayhem, earthquakes and killer tornadoes, bombing campaigns and wars.

Radio, too, is everywhere with its loud, violent music, its mindless commercials, and its talk-show hosts’ pontificating for hours at a time. Even those who agree with the latter sometimes want to mutter, “Well, Dr. Laura,

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it must be nice to know so much that you can answer a question before the person has even finished asking it” or “Oh, stop shouting, Rush!”

Telephones, once stationary, now accompany the garrulous wherever they happen to go, assailing us with other people’s business when we’re standing in a grocery-store line, dead-tired after a day’s work, or walking down a street, enjoying the peace of a lovely day. Beepers go off in the middle of meetings or parties; even computers and automobiles “talk.”

The problem is not only the pervasiveness of nerve-jangling noise but also, and more importantly, the content of our mass media. Decades ago, cultural critic William F. Lynch remarked that Hollywood needed to receive “a continuing protest that we may be good or we may be bad but we, as human beings, are not junk in our inner apparatus.”² And that was before things were truly out of control. Now, 50 years into the TV age, tasteless films and television programs kill our souls, whether by being actively violent and pornographic; merely stupid, like situation comedies whose producers think the viewers need laugh tracks; or vulgar, like commercials for personal-hygiene products. The powers-that-be in television appear to have little respect for the human body or the human person. It is hard to find on TV any hint of the potential greatness or nobility of human beings.

Personal computers, the major revolution of recent decades, make a wealth of information easily available. Their word-processing capability is a great aid to writers, lawyers, and office workers. Yet computers, like many other inventions, are a mixed blessing. The Internet is a major purveyor of pornography and violence; it passes on much misinformation; and it leads many people to prefer “virtual reality” to reality itself. (After seeing a piece touting an astronomy Web site for its beautiful views, I thought, “Well, hey, guys, did you ever think of walking outside at night to see the real thing?”)

Advertising, on television and online, is a major engine of our economy. It burns commercialism into our very souls. It teaches children to say, “Gimme!” and “More!” and it pushes their parents to run faster on the treadmill to make more money in order to buy more *stuff*. And buy more stuff they do: bigger and more expensive cars and houses, more than enough clothing and shoes. They spend bundles of money on labor-saving devices; then, fearing health problems from lack of exercise, they put large sums into exercise equipment and fitness centers. (Wouldn’t it make more sense to forego, say, both the riding lawn mower and the exercise machine—and to get more exercise by pushing an old-fashioned mower?)

There would be a redeeming feature in our frenetic work pace if the possessions it pays for at least had grace and charm. But so often they do not: the “McMansions,” which are gobbling up beautiful farmland at an alarming

rate, illustrate the problem. Architect Sarah Susanka summed it up this way: "So many houses, so big with so little soul." She described a venture into contemporary suburbia where she felt "as though I was driving through a collection of massive storage containers for people."³

Sherlock Holmes referred to "that supreme gift of the artist, the knowledge of when to stop."⁴ Our architecture today, and much else in our culture, are marked by the lack of that gift. There is a heaviness in the mini-mansions, the oppressive office buildings, and what someone called the "Pizza Hut churches." We desperately need a light touch.

No Magic Wand, But . . .

There is no magic wand that we can wave to improve our dreary culture. Yet we can make our own decisions to keep our distance from its worst aspects, and we can try to foster the joy of life for ourselves and others. If enough of us make such decisions, we can gradually change the culture—one person and one family at a time.

What to do about television is a central question. Philosopher Sissela Bok, in *Mayhem: Violence as Public Entertainment*, notes that screening devices such as the V-chip and Cyber Patrol can help parents protect their children from the worst programs. She promotes school "media literacy" programs that show youngsters how to analyze TV programs and, if so inclined, to act against objectionable ones. She also notes possibilities ranging from lobbying TV executives for better programming to boycotting the sponsors of objectionable programs. "Cultures are not frozen in stone," she writes. "Violence is taught, promoted, glamorized; it can be unlearned, resisted, deglamorized."⁵

However, there have been many such efforts to improve TV in recent decades, and yet the beast has become ever more violent and sleazy. Michael and Diane Medved have a more radical idea: drastically reduce family viewing time, and consider getting rid of television altogether. In *Saving Childhood*, the Medveds note that televised fiction is by no means the only problem. Television news, they say, gives children a "sad, horrific, and harsh view of the world." The medium also encourages impatience (through its quickly-changing images), self-pity (through its commercials' "emphasis on lack and need") and superficiality (through its "preoccupation with glamour and good looks").⁶

Realizing that many people cannot quit TV cold-turkey, the Medveds recommend strategies for phasing it out. Remove all TV sets from bedrooms, they suggest, and then from the living room and kitchen. Confine the monster to just one room, and then make it more difficult to watch. "Cover it

with a tablecloth, and top that with a potted plant . . .”⁷

Another path, and one the Medved family follows, is to have a television set, but no antenna or cable connection. They use their set only to watch videos. The parents carefully screen the videos their three young children watch, and they limit the children to six hours of videos per week. When I described this system to a mother of four, she responded: “Try that when they’re teenagers.” A good point; yet the Medved system at least gives a fighting chance to alternatives such as playing outdoors and reading books.

The benefits of doing without television are very great: genuine peace and quiet, freedom from non-stop advertising, time to read books and talk to one another. Best of all, perhaps, is the freedom from the social and political indoctrination that television inflicts on everyone who watches it. If only ten or fifteen percent of Americans were free of it, I suspect, they would make our politics far more independent. By showing that no one has to accept what Hollywood deigns to offer, they might even improve the culture.

On the broader problem of too many possessions, there is wisdom in a rhyme I learned from one of my grandmothers: “Eat it up/Wear it out/Make it do/Or do without.” We may not give up automobiles, but most of us do not need huge gas-guzzlers or sports utility vehicles. We may not give up electricity, but we can do without many of the gadgets that it powers.

Few material things are more important to us than our homes. Probably most of us feel about them the way John Wemmick, the law clerk in *Great Expectations*, felt about his. Mr. Wemmick’s tiny cottage was a true refuge; it looked like a castle and was surrounded by a moat. A simple plank served as his drawbridge. “After I have crossed this bridge,” he said, “I hoist it up—so—and cut off the communication.” Every night at nine o’clock, he fired a cannon from his little domain, to the delight of his father (the “Aged Parent” or “Aged P.”). No office-at-home routine for Wemmick: “. . . when I come into the Castle, I leave the office behind me.”⁸

But Wemmick’s castle was a small one. He had not taken on a lifetime of financial strain to pay for it. Many people today would be far happier if they bought smaller, less grandiose homes. Young couples who are just starting out might resist advertising pressures by reflecting that most people are far more impressed by a happy marriage than by a huge house or expensive car. Even wealthy couples who are tempted by mini-mansions might consider buying more modest homes and donating the difference to Habitat for Humanity so that poor and working-class people can have homes, too. Such generosity might well give them more contentment than a trophy home would.

We can show children that real life is more interesting and exciting than

its electronic and processed versions. We can walk in the woods with them; teach them about bird calls and beaver dams; go canoeing with them; show them how to plant a garden; visit a farm with them; take them out to a ball game; take them to an historic site and tell them about the exciting things that happened there.

"All of this sounds very nice and noble," some may say, "but where are we to find the *time* to do such things?" Forgive my mentioning it again, but getting rid of television provides more than enough time—about 24 hours per week on average, according to the Medveds.⁹ Doing such things with children and teenagers may give them an interest in lifestyles and careers they otherwise would never have considered, ones that may bring them great happiness and enable them to give happiness to others. As Lady Bird Johnson, who has done so much to increase the joy of life through wildflowers, put it: "You should work at the projects that will make your heart sing."¹⁰ We need talented park rangers, florists, and nursery owners. We need accomplished farmers, musicians, and artists. Great architects, teachers and writers.

Young people should know that they do not have to accept today's culture as given, that they can make a conscious effort to offer something better to their peers and later to their own children. They can follow the example of Frances Hodgson Burnett, author of *The Secret Garden*, who once said, "With the best that I have in me, I have tried to write more happiness into the world."¹¹

New Hope for Mental Patients

In addition to cultural depression, some people must deal with severe clinical depression, manic depression, or schizophrenia. It is hard to imagine greater roadblocks than these to the pursuit of happiness.

Yet there is genuine hope for mental patients in new medicines and in programs that provide both practical and psychological support. There is special hope in the fact that recovering mental patients are helping to design and run programs from their first-hand knowledge and that articulate family members are supporting and publicizing such programs.

Jay Neugeboren, whose brother Robert has struggled for decades with severe mental illness, believes that family members should not assume that only a complete cure can enable their loved one to lead a relatively normal life. Instead, he argues that "one can recover and reclaim responsibility for one's life without having to be fully cured" and that "one can have a full life while still having symptoms."¹² This is good news indeed, because there are still many unknowns about the precise causes of major brain disorders. While some people obtain complete cures, and while there is much promising

research, there is no guarantee that total cures will be found for everyone.¹³

Neugeboren tells many success stories in his splendid book, *Transforming Madness*. One of his favorite examples is Moe Armstrong, an ex-Marine who had a schizophrenic breakdown in Vietnam and spent many years afterwards as a wanderer, addicted to alcohol and street drugs. People with serious mental illness often “self-medicate” with these substances, which may give temporary relief but generally make their illness worse. Armstrong had “auditory and visual hallucinations, suicidal fits of depression, and wild fits of rage.” He married and divorced several times. Finally, though, he was able to leave street drugs and alcohol behind and to earn several university degrees. Sometimes with anti-psychotic drugs, sometimes without, Armstrong leads a rewarding life helping other mental patients in his full-time job with the non-profit Vinfen Corporation in Massachusetts. He does this despite still having hallucinations and depression at times.

A big, kind, and immensely creative man who enjoys music, writing poetry and drawing cartoons, Armstrong has hard-earned wisdom about helping people with mental illness. Most of us wouldn’t think of medical-alert bracelets, for example, but Armstrong explained that: “There’s almost no stigma attached to med bracelets, and that way when a cop has to deal with us, he’ll know who we are, and can get us back to our residences, or clinics, or to our case managers, and not be dragging us to court or jail.” He stressed that there is no one-size-fits-all solution: “There is no such thing as *a* schizophrenic or *a* manic-depressive or *a* borderline,” he says. “We’re each different, and our problems each need different solutions. Otherwise, it’s like trying to put square pegs into round holes.” He stops. “And what if I’m a hexagon? A lot of us are hexagons, you know.”

“You can avoid a lot of mistakes if you simply talk with people,” Armstrong said. “You can increase levels of understanding, and—for starters—find out what triggers their breaks by asking them what *they* think helps, and what they *know* sets them off. That way you can avoid a lot of things that bring on breakdowns and lengthy hospitalizations.”¹⁴

Shery Mead did this at a respite center she started in New Hampshire. Like Armstrong, Mead has struggled with severe mental illness for most of her life. A former music teacher and professional guitarist, she started a residence offering short-term stays for people in crisis who want to avoid hospitalization. Such people must, in advance of an emergency, come to the center and formulate their crisis plan. Center staff, themselves recovering mental patients, help them by asking questions such as “When you are bouncing off the walls, is it best to leave you alone, or to put an arm around you?” or, “When you had breakdowns before, what helped—and what hurt?” or, “What

do you keep hidden from people when you are in a crisis?"

While it does not offer psychiatric treatment, the center provides a safe and kind place to stay—with friendship and support from people who have “been there.” Jay Neugeboren says that it has given people in crisis “somebody to talk with and be with when they wanted—which they never had in hospitals, where mostly they were left alone.” It has enabled many people to avoid hospitalization and has given them new hope and new ability to help themselves. It also has saved a significant amount of money for the State of New Hampshire: In 1997, state hospitalization cost about \$500 per day, while the respite center cost roughly \$130 per day.¹⁵

It is not enough to help mental patients only when they are threatened by breakdowns. They also need help in finding and keeping jobs, help like that provided by another New Hampshire program, run by the West Central Services mental health center. The work is not glamorous—janitorial and mailroom tasks, for example—but it gives them income and a growth in confidence. “For persons who have been hospitalized and brutalized and out of it for years,” a West Central staff member told Neugeboren, “simply being able to think of themselves as something other than mental cases—loons or nuts or schizos—and to have others not think of them this way—can make all the difference.”¹⁶

There is widespread agreement that programs like these should have been in place when, decades ago, states started releasing huge numbers of patients from mental hospitals. Because most states did not have effective programs in place, many mental patients wound up on the streets, in subway stations, in homeless shelters, in jails and prisons, or out in the woods somewhere. Many are still there.

Observers have often blamed deinstitutionalization on lawyers and judges who opposed involuntary commitment even for people who posed a clear danger to themselves or others. Yet, as psychiatrist E. Fuller Torrey notes, state governments were eager to release patients so they could shift costs from their own budgets to federal programs such as Medicaid, Supplemental Security Income (SSI), and food stamps. Dr. Torrey contends that mental patients were “driven out” of state mental hospitals “by the odd alliance of civil liberties lawyers and conservative state legislators who encouraged deinstitutionalization to save state funds.” This combination, he says, caused the process “to careen out of control and down a steep embankment, where it remains to this day.”¹⁷

Releasing patients without providing a safety net has led to additional misery for people who already suffer torments from hallucinations, delusions, compulsions and/or paranoia that most of us cannot imagine. It may

have been penny-wise but pound-foolish for the states, too. They may have paid more to house severely mentally-ill people in jails or prisons than they would have paid for good programs of support in the community.

There is a tendency to rely on “magic bullet” medications to deal with severe brain disorders. Some of the newer drugs *are* an enormous help to many patients, even leading to Rip Van Winkle stories of people who return to relatively normal life after many years in institutions or out on the streets. Some drugs even stop the “voices” that torment so many schizophrenics.¹⁸

Yet a significant number of mental patients are helped little, if at all, by the new drugs. And, old or new, mood stabilizers and antipsychotic drugs have side effects that may include sedation, great thirst, hair loss, involuntary twitching and grimacing, restlessness and constant pacing, drooling, incontinence, major weight gain, nausea, skin disorders, kidney or liver damage, serious decline in white blood cells, dizziness and headaches.¹⁹ This is one reason why so many patients stop taking their medications. Generally speaking, though, the new drugs have fewer and less serious side effects than the old ones. Where side effects are a problem, reduced dosages or substitute drugs may solve them. In any case, careful monitoring is essential.

Many patients also need “talk therapy” to help them deal with their illness. As psychologist Kay Jamison wrote about her own battles with manic depression, “psychotherapy heals. It makes some sense of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all No pill can help me deal with the problem of not wanting to take pills; likewise, no amount of psychotherapy alone can prevent my manias and depressions. I need both.”²⁰ Many patients also need the kind of consistent support in the community that the Vinfen Corporation, West Central Services, respite centers, and other programs provide.

Many family members, though, cannot pay for such care out of their own pockets without facing bankruptcy in short order. Writer Peter Wyden acknowledged that it “pains and shames me every day” to know that his son Jeff—afflicted with severe mental illness for roughly thirty years—was on welfare and that “his mother and I are reduced to beggars who can’t be choosers. . . . Until Jeff can produce some income and his need of medical support is greatly reduced, the cost of his care is such that it would soon wipe us out, which would help no one.” Wyden, still working in his seventies, stressed that he had “paid hundreds of thousands of dollars to Jeff’s doctors and hospitals as long as I could” and added that “I’m still supplementing the government efforts with more thousands of my own and working as best I can to get Jeff off his dole.”²¹

What We Can Do

The case for government programs to aid those who have severe mental illness is stronger, it seems to me, than for nearly any other kind of government spending. Not only are these people severely disabled, but often their suffering is beyond what most of us can comprehend. Too often, though, programs to help people with severe mental illness are among the first to be cut when times are hard.²² We need firm resolve to give them first priority instead of last.

This does not mean, of course, that just spending money is enough. The federally-funded Community Mental Health Centers that were started in the 1960s as alternatives to state mental hospitals were failures, at least in part, according to Dr. Torrey, because they focused too much on caring for “the worried well” instead of those with severe mental illness.²³ In designing programs, advocates and government leaders should keep in mind a cowboy saying about choice of horses: “Careful what ya rope, ya gotta ride it.”²⁴ But there are plenty of good programs out there, and many good people who know what works.

One key to success is involving mental patients themselves in the establishment and running of such programs. So is having a stable program and kind, well-trained staff. People who are adrift on the terrifying seas of mental illness desperately need steady anchors. Some have been harmed almost as much by cold, uncaring staff—or by arbitrary transfers of good staff—as by their illness itself.

Larry Kohn, who directs a Boston University program to train mental patients in computer skills, exemplifies the traits a person working in his field should have. One of his clients, who has serious depression and multiple personality disorder, had to be hospitalized during her computer studies. Kohn visited her several times, and she thought, “He really cares about *me* . . . He must believe in *me*, then, doesn’t he?” Later she said, “That made more difference than all the pills. It fired my will to keep going.” A man with manic depression said that Kohn “was the first person to make me feel like a *person* instead of a *patient* . . . He was the older brother I never had. There’s a lot of terror in psychiatric illness, you see, and it makes all the difference in the world to have someone there with you in the darkness.”²⁵

Programs like the one Larry Kohn runs help people with mental illness become as self-sufficient as possible. With proper medication and support, even those with severe mental illness can work at least part-time. Many can work full-time at jobs ranging from unskilled labor to extremely demanding and creative work. If properly assisted at first diagnosis and in times of cri-

sis, many will need little public support; some will recover to the point where they no longer need medications. But, unless complete cures are found, most will always need some form of care. "I believe that for most of us," Moe Armstrong said, "having a psychiatric disorder is going to require low-cost lifetime maintenance, the way diabetes and other chronic conditions do."²⁶

Those who do not have such disorders can help those who do by being knowledgeable and consistent advocates on public-policy issues. This might include advocacy on choice of programs ("Careful what ya rope"), support for adequate funding, or a welcome wagon for group homes in neighborhoods. Hostility toward such homes for mental patients has been a major obstacle to good programs.²⁷

Friendship and support for mental patients is especially important. Extreme loneliness is one of the worst burdens mental patients carry. One woman recalled how her son had been doing fairly well but then had to be rehospitalized. What he received in the way of outside support, she said, was "nothing: no visits, no cards, no calls, no flowers."²⁸ Friends and family should have responded in the same way they would have if the young man had appendicitis or pneumonia. Yet there is still much stigma attached to mental illness—and much fear of those who have it. While there is reason to fear those who have been violent in the past and now refuse treatment, most mental patients are not violent. "We're really harmless and scared for the most part," Moe Armstrong said. ". . . As a group, especially given all the meds we take, we're about the most frightened, mild-mannered, unthreatening folks you'll ever meet."²⁹

With proper care and support from the public, recovering mental patients can experience the joy of life. Shery Mead, whose personal interests include cross-country skiing, triathlons and hang gliding, would like to take current programs even further. "Why isn't there more *adventure* therapy?" she wonders. "Let's talk more about adventure—about putting more *life* into our lives—and less about what might go wrong, okay?"³⁰

Amen to that.

A Garden of Eden for Seniors

Fiercely independent, the 76-year-old California lady had resisted having help in her home that she really needed. She was in poor health, with high blood pressure and leg infections from a fall. She was not eating properly or taking care of personal hygiene. Then suddenly she lost her home because she hadn't kept up her mortgage payments.

Her daughter, who lived and worked on the East Coast and did not know about the eviction, flew out to see her. Walking in on disaster compounded,

the daughter had to make emergency plans right away. Her mother remarked wistfully, "I never thought anything like this could happen to a little old lady like me."³¹

There are, of course, many ways to help aging parents stay in their own homes and be relatively independent. These range from hiring cleaning or bookkeeping assistance and home health aides to obtaining "Lifeline" devices to summon help in an emergency. The trick is to persuade seniors to accept such help before emergencies occur.³²

Many seniors want to retain their independence but shed the burden of maintaining a house. Condominium, independent-living, or assisted-living communities are often good alternatives for them. Sometimes, though, poor health or senility makes a nursing home the only viable alternative—although one that many seniors dread as the "last stop." Ironically, while the overwhelming majority of seniors do *not* wind up in nursing homes,³³ the fear of doing so at the end of their lives robs many older people of the joys of retirement.

There are enough mediocre and poor nursing homes to justify seniors' anxiety. And even many of the good homes have an impersonal and regimented atmosphere that kills the soul. "Loneliness, helplessness, and boredom rage as fiercely in good homes as in bad ones," says Dr. William H. Thomas.³⁴

In the early 1990's, Dr. Thomas, medical director of the Chase Memorial Nursing Home in rural New Berlin, New York, designed a radical solution for the problem. Why not, he asked, turn away from the ultra-medical model and make his nursing home over into a *real* home, where seniors could actually enjoy life? Why not make it something like the Garden of Eden?

With much help from his colleagues, Thomas started to "edenize" the Chase home. He was so successful that many other nursing homes have followed his example.

Edenization involves two major changes. The first is to fill the home with children, pets, plants, and flowers. These make the seniors' "habitat" more natural and joyful.

The second change is to release the home's staff from what Dr. Thomas calls "a paramilitary command structure," giving them instead a team approach in which they have substantial responsibility for their own work and schedules. This improves life for both staff and residents. "Tightly restrict workers' daily routines with rules and regulations," Thomas says, "and you can expect the same to be visited on residents. . . . Residents will never have more autonomy or self-respect than that which nursing home managers grant their employees."³⁵

A study that compared the edenized Chase home with a traditional nursing home found that Chase had a lower mortality rate and less staff turnover. The infection rate among Chase residents dropped significantly after edenization, and residents needed fewer medications than before. Thomas, who believes that nursing homes tend to over-medicate their residents, was especially happy to see a reduction in the use of mind-altering drugs. One Chase resident, for example, had been taking haloperidol, an antipsychotic drug, because of her agitation. But after she started helping care for the home's many pet birds, she no longer needed the drug. "The daily routine with one hundred parakeets," Thomas reports, "did more to soothe the agitation than the medication did."³⁶

Many nursing homes have groups of schoolchildren come in occasionally for a Halloween party or to sing Christmas carols. An edenized home goes far beyond this. Chase has its own child care center, an after-school program for students, and a summer camp. The home also hosts meetings of youth groups such as Brownies and Cub Scouts, and it even started a 4-H group for its rural area. The Chase volunteer program offers fifth- and sixth-grade students the chance to spend an entire day helping with plant and animal care and socializing with the seniors. The hubbub of children, Thomas says, "injects vitality into any environment. Their play, laughter, and song are potent medicines for the elderly."³⁷

Resident dogs, cats, and parakeets offer the seniors another antidote to loneliness and boredom. Having so many pets around requires careful attention to selection, cleanliness and veterinary care; but Thomas believes the results are well worth the effort. He mentions one resident who was so devoted to her parakeets that, when hospitalized temporarily, she had to be assured that Sweetie and Tweetie were being well-cared for before she could turn her attention to her own recovery. Another resident, newly admitted after his wife's death, was so depressed that all conventional efforts to help him failed. He stopped walking and eating—until he received two parakeets as companions. They eased his loneliness and restored his interest in life; soon he was able to return to his own home.³⁸

Dr. Thomas says that edenization "requires much more change in the heart than in the pocket" and that its costs "are minimal compared with the facility's total budget." For example, in building a wildlife habitat on the grounds, "the more time you have, the less money you need"—and nursing homes "have plenty of time." Thomas also notes the possibility of obtaining financial aid from community groups, government agencies, or foundations.³⁹

I suspect that many more nursing homes will opt for edenization if their

residents actively work for change, as mental patients are now doing in their sphere. Organizing for change can itself reduce the deadly boredom and passivity that too often afflict nursing-home residents. The changes they win will help restore their joy of life.

Many residents, though, are too frail or depressed to speak up on their own behalf. They need help from family and friends, who should be present as visitors and volunteers in much larger numbers than they now are. H. B. "Corky" Rogers, chaplain of a Denver nursing home, talks of the need to "flood the nursing homes with volunteers." One visit at Christmastime, he remarks, "is not where the rubber meets the road."⁴⁰

Flooding the homes with visitors and volunteers could in itself radically improve the residents' quality of life. There would be many more people to take wheelchair users outside on good days, to be special friends of residents who have no family left, and to offer more intellectually-stimulating programs than most homes now have. Mr. Rogers, addressing his fellow Christians, made a comment that people of other faiths, or no faith, should also think about: "If the Christians across America would commit at least one hour per week of service to a nursing home, the nursing home industry would make a dramatic turn for the better. . . . And, the terrible financial crunch in the industry wouldn't make any difference."⁴¹ Such visitors and volunteers, after learning the ropes, could also be effective change agents within the nursing homes.

Support and Honor the Caregivers

Every effort to aid people with disabilities and to enhance their joy of life should focus on helping them be as self-sufficient as possible. Some well-intentioned efforts fail because they are essentially paternalistic. Their designers forgot to ask the intended beneficiaries what they wanted and needed and what they could do to help themselves.

Yet there is, and always will be, a great need for skilled caregivers: nurses, nursing aides and attendants, physical therapists, psychotherapists, and social workers. In order to do their work well, and to stay with it for the long haul, they need support and honor.

Fair pay and good working conditions for nursing aides should be a high priority. Many of them make little more than the minimum wage, yet their work is among the most difficult—and most important—that anyone does. They should make more money, even if that means that wealthy executives of healthcare companies make less.

As Dr. Thomas pointed out, reducing the bureaucracy at the top and moving away from a "paramilitary command structure" to teamwork may be the best

way to improve working conditions of both nurses and nursing aides. They, too, deserve the joy of life.

So do those who care for disabled family members in their homes or serve as advocates for them within the confusing bureaucracy of psychiatric care. Yet family caregivers often suffer from extreme isolation, receiving the occasional pat on the back but very little practical help. "Where's our support?" asked one. "We're not professionals. We haven't taken one single course in this field and yet we're supposed to handle these crises all alone." A man whose son was schizophrenic remarked, "The stigma of a mental disorder causes you to lose many friends. Even family members back off; they're not around very much. I feel shunned by them. Our friends and family have not been supportive."⁴²

Home caregivers, no matter how devoted, need a break from their hard work and crushing responsibility. Respite programs—public or private, professional or volunteer—can be lifesavers for them. But they also need more support from other family members,⁴³ and from friends and neighbors as well. Visits are good, but getting *both* the disabled person and the caregiver out into the community is even better. Here we might follow the example of Leslie Girard, who several years ago started a "Roll 'em Out" program for a Virginia nursing home. Realizing that many residents rarely if ever had a chance to go outside, she organized an annual event in which volunteers take residents out into the neighborhood. She hoped that the program would lead family members to "roll 'em out" on a regular basis.⁴⁴ A similar effort is needed for people who are cared for at home and for their caregivers. Community picnics and block parties offer good occasions for this, and others can be found or invented. Sunshine, fresh air, and friendship can do wonders for people who have been cooped up inside for a long while.

I suspect that failures to include disabled people and their caregivers in neighborhood events are due partly to oversight and partly to an awkwardness or embarrassment that many of us learned as children. "Never stare at someone who has a handicap," we were told, and that made us all the more curious, more likely to sneak quick glances (but avoid eye contact) and less likely to be at ease in the presence of disability.

What both children and adults need to learn is that living with a disability is just a different way of being. As disability-rights activist Mary Jane Owen has said, "developing a few glitches, developing impairments, is *not* the end of the joy of life . . . we can enjoy life learning new functions and new ways of being."⁴⁵ If we live long enough, all of us will develop glitches and impairments. Those who do not have them at the moment should be matter-of-fact in dealing with others' wheelchairs, guide dogs, and so on—offering assistance

where needed, but not making a great fuss. The basic approach should be: "No big deal. This is just another way to get around."

Society generally gets more of what or whom it honors. Given today's celebrity culture, we can expect to see many more rock singers and Hollywood aspirants, more sports heroes and warriors and astronauts—but not many more caregivers who work with those most in need. People asked one nurse who worked in a nursing home, "Why are you wasting your training there?" They asked another, "Honey, why don't you work in a hospital and be a real nurse?"⁴⁶

Those who see things differently can help by saying, "A nursing home? That's wonderful! You can make a real difference in many people's lives." Or: "You're considering physical therapy as a career? That's one of the most important jobs in the world. Go for it!" Perhaps, in response to the tabloid press and *People* magazine, we need a magazine called *Good People* about caregivers and advocates. Perhaps there should be a Nobel Prize for people such as Moe Armstrong, Shery Mead, and William Thomas. The next round of Presidential Medals of Freedom should include one for an outstanding nursing aide.⁴⁷

In honoring such people, and in thinking of all the work that remains to be done, we might remember something said by James Huneker, an American writer of the early 1900s. Huneker called himself a "Yea-sayer to life."⁴⁸ If we all have this approach, we can do much to recapture the joy of life for ourselves and others.

NOTES

1. Peggy Noonan, *Life, Liberty and the Pursuit of Happiness* (New York: Random House, 1994), 213.
2. William F. Lynch, *The Image Industries* (New York: Sheed & Ward, 1959), 54.
3. Sarah Susanka and Kira Obolensky, *The Not So Big House: A Blueprint for the Way We Really Live* (Newtown, Conn.: Taunton Press, 1998), 7 & 9.
4. Arthur Conan Doyle, "The Adventure of the Norwood Builder," in *The Complete Sherlock Holmes* (New York: Doubleday, n.d.), 510.
5. Sissela Bok, *Mayhem: Violence as Public Entertainment* (Reading, Mass.: Addison-Wesley, 1998), 157.
6. Michael Medved and Diane Medved, *Saving Childhood: Protecting Our Children from the National Assault on Innocence* (New York: HarperCollins, 1998), 35 & 42-49. The Medveds offer excellent suggestions for giving children a secure and happy childhood.
7. *Ibid.*, 255-256.
8. Charles Dickens, *Great Expectations* (London: Oxford, 1975), 195-197 ff. & 283.
9. Medved and Medved, op. cit. (n. 6), 19.
10. Quoted in Paul Hendrickson, "Lady Bird: The Heart and the Hurt," *Washington Post*, 8 Dec. 1983, D-1. Mrs. Johnson, widow of the late President Lyndon B. Johnson, described her National Wildflower Research Center with engaging modesty: "This is my last hurrah. We're going to have to work awfully hard to make this kite fly. We want to start in Texas and work outward. . . . I don't know how you begin something nationally unless you're a very big person."

- I'm just a little bitty person." Ibid., D-17.
11. Quoted in Ann Thwaite, *Waiting for the Party: the Life of Frances Hodgson Burnett, 1849-1924* (New York: Scribner, 1974), 247.
 12. Jay Neugeboren, *Transforming Madness: New Lives for People Living with Mental Illness* (New York: Morrow, 1999), 27. Written with an unusual blend of realism and hope, this book offers a wealth of information on outstanding advocates and programs.
 13. See Nancy C. Andreasen, *Brave New Brain: Conquering Mental Illness in the Era of the Genome* (New York: Oxford, 2001), for information on current research.
 14. Neugeboren, op. cit. (n. 12), 32-40, 45-47, 38, 43 & 50. Armstrong found the antipsychotic drug Risperdal extremely helpful but had to stop using it because of side effects. After dropping it, he suffered greatly from night terrors, but then had a period of good health thanks to a combination of exercise, meditation, amino acids, and vitamin B-6. According to a recent report, he is now using antipsychotic medicine once again; he explains that he avoids movies because they make him "over-amped," and that he needs "supportive, gentle, loving environments." Ibid., 338-40; and Moe Armstrong, quoted in Sandra G. Boodman, "'Beautiful'—but Not Rare—Recovery," *Washington Post* "Health" section, 12 Feb. 2002, F-4. Boodman describes a number of people who have recovered from schizophrenia to the point where they no longer need drugs.
 15. Neugeboren, op. cit. (n. 12), 164-165, 173-184 & 340-341. The respite program is still in existence. While Shery Mead no longer runs it, she is still active in peer-support work.
 16. Ibid., 152-162, 159.
 17. E. Fuller Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* (New York: Wiley, 1997), 91-109 & 144.
 18. Stephen Mark Goldfinger, foreword to Ken Steele and Claire Berman, *The Day the Voices Stopped* (New York: Basic Books/Perseus, 2001), xi. This book tells the sad but ultimately triumphant story of the late Ken Steele. The voices, which had insulted him and goaded him to suicide attempts for over thirty years, finally stopped after he started taking Risperdal. Ibid., 192-207.
 19. E. Fuller Torrey and Michael B. Knable, *Surviving Manic Depression: A Manual on Bipolar Disorder for Patients, Families, and Providers* (New York: Basic Books/Perseus, 2002), 137-161 & 177-187. It is important for patients and family members to know that some drugs may cause mental illness in people who otherwise would not have it. Illegal street drugs can produce mania, hallucinations, paranoia and depression; and some prescription drugs can cause mania or depression. Ibid., 63-70. Birth-control pills, fertility drugs, and hormone replacement therapy can lead to depression. See Deborah Sichel and Jeanne Watson Driscoll, *Women's Moods: What Every Woman Must Know About Hormones, the Brain, and Emotional Health* (New York: Morrow, 1999), 24-25, 153, 165-166, 266 & 307. Thus, stopping some drugs, rather than starting others, may be the right answer.
 20. Kay Redfield Jamison, *An Unquiet Mind: A Memoir of Moods and Madness* (New York: Knopf, 1995), 89, (original in italics). "Psychotherapy" does not necessarily mean Freudian psychoanalysis. There are other kinds of therapy that are more helpful to many patients. Yet many managed care companies are willing to pay for "magic-bullet" medications but not for the therapy that so often should accompany them. See Andreasen, op. cit. (n. 13), 339-341. For other problems with managed care in psychiatry, see Torrey, op. cit., *Out of the Shadows* (n. 17), 122-128.
 21. Peter Wyden, *Conquering Schizophrenia: A Father, His Son, and a Medical Breakthrough* (New York: Knopf, 1998), 273-275. Note Wyden's poignant remark that "I kept thinking that my long job of raising this son was done. Instead, I am in my seventies, and the task continues." Ibid., 39. His book, based on much research as well as his personal experience, is well-written and valuable.
 22. Funding cuts and lack of care sometimes result in suicides. See William Branigin, "Mentally Ill Find More Doors Shut," *Washington Post*, 24 June 2002, B-1 & B-5.
 23. E. Fuller Torrey, *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill* (New York: Harper & Row, 1989), 25-29, 106-156 & 168-198. Torrey offers a devastating account of the federal government's role.
 24. Quoted in Jo Rainbolt, *The Last Cowboy: Twilight Era of the Horseback Cowhand, 1900-1940* (Helena, Mon.: American & World Geographic Publishing, 1992), 21.
 25. Quoted in Neugeboren, op. cit. (n. 12), 71 & 79.

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26. Quoted in *ibid.*, 43.
27. *Ibid.*, 58-64 & 83.
28. *Ibid.*, 150
29. *Ibid.*, 38.
30. *Ibid.*, 163.
31. Marie Spake, quoted in Amanda Spake, "'Nursing Home' Were the Two Words I Dreaded Most to Hear," *Washington Post* "Health" section, 13 March 1990, 14.
32. For ideas on how to do this, see Claire Berman, *Caring for Yourself While Caring for Your Aging Parents: How to Help, How to Survive*, 2nd ed., (New York: Holt, 2001); and Grace Lebow and others, *Coping With Your Difficult Older Parent: A Guide for Stressed-Out Children* (New York: Avon, 1999).
33. Amanda Spake, "Programs to Help Adult Children Care for Parents Are Scarce," *Washington Post* "Health" section, 13 March 1990, 16.
34. William H. Thomas, *Life Worth Living: How Someone You Love Can Still Enjoy Life in a Nursing Home* (Acton, Mass.: VanderWyk & Burnham/Publicom, 1996), 93.
35. *Ibid.*, 69-70 & 71-86.
36. *Ibid.*, 56-57; 75; center insert, figure 8; and 47-52.
37. *Ibid.*, 101.
38. *Ibid.*, 58 & 44-45.
39. *Ibid.*, 96, 159 & 168-169. Edenization can *reduce* expenses by reducing staff turnover, infections, and use of medications. For more information on the theory and practice of the Eden Alternative: www.edenalt.com; and Beth Baker, "Old Age in Brave New Settings," *Washington Post* "Health" section, 16 July 2002, F-1 & F-6.
40. H. B. "Corky" Rogers, *Project Compassion for the Elderly* (Denver: Good News Communications, 1984), 8, 45, & 73.
41. *Ibid.*, 67 (original in upper case).
42. Sandra Wolfenbarger and "Tom," quoted in Rosalynn Carter and Susan K. Golant, *Helping Yourself Help Others: A Book for Caregivers* (New York: Times Books/Random House, 1994), 110 & 112.
43. See Berman, *op. cit.* (n. 32); Joan Hunter Cooper and others, *Fourteen Friends' Guide to Eldercaring* (Sterling, Va.: Capital Books, 1999); and Carter and Golant, *op. cit.* (n. 42). These books also suggest other ways to avoid burnout.
44. Christian Toto, "Seniors Get Push Toward Mobility," *Washington Times*, 1 June 2000, C-4.
45. Mary Jane Owen, telephone interview by the author, tape recording, 31 July 1992.
46. Alice Kaye Moser, "'Wasting' Your Nursing Talents on the Elderly," *Washington Post*, 9 May 1982, D-3; and "S.C." in Ann Landers' column, *ibid.*, 16 Jan. 1991, C-6.
47. An example is Vera McGriff, profiled by Lorraine Adams in "A Caregiver Persists Despite the Indignities," *ibid.*, 1 Nov. 1999, A-1 & A-5. *People* magazine does run occasional profiles of people who help others, but its overwhelming emphasis is on celebrity, glamour and glitz.
48. Quoted in Van Wyck Brooks, *The Confident Years: 1885-1915* (New York: Dutton, 1955), 148.

The Principle of Hope

Sherwin B. Nuland

The Case Against Assisted Suicide:

For the Right to End-of-Life Care

edited by Kathleen Foley and Herbert Hendin

(Johns Hopkins University Press, 371 pp., \$49.95)

I.

As every doctor knows, the number of operations that have been devised for a given pathology is inversely proportional to the probability that any of them is entirely satisfactory. Thus there have been dozens of surgical methods designed to treat the notoriously resistant problem of acid reflux disease, but there has been only a single technique for appendicitis, because it succeeds every time.

The opposite can be said about the number of definitions for a given noun. The more there are, the more valuable is each one. Multiple definitions, each subtly different from all the others, convey multiple shades of meaning. They expand the uses of the word and the contexts in which it can appear; language is enriched, thought is widened, and interpretations increase or dilate to fill the potentialities of association. The very impossibility of absolute-ness in the definition of certain nouns adds to the levels of connotation they may reach. The inner life of a writer says more than most readers can know; the mind of a reader discovers truths that go beyond the intent or perhaps even the comprehension of the writer. And all of it finds expression because a word can mean many things.

“Hope” is such a noun. In thinking about its multiplicity of uses, we might consider for a moment what “every doctor knows,” beyond the data and the complexities of human biology and its discontents. For if there is a single theme interwoven into the education of all medical students and verified in the crucible of daily experience, it is the unstated precept that hope is the subtext of every encounter that a doctor will ever have with a fellow human being who is sick. People come to us seeking hope, and we are meant to convey hope in every facial expression and clinical intervention that we undertake. Hope is a powerful element in the therapeutic arsenal. Almost always, it is synonymous with a reassuring optimism that we can do something to fend off the depredations of a disease.

But what happens when there is no treatment adequate to fight the malady?

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As a student I was taught—and for four decades I have taught others—that under no circumstances must a physician allow a patient to lose hope. Of what, then, does hope consist, when there can be no optimism that cure will be attained or life lengthened? How can the word be defined for a man or woman whose life is near its inevitable end?

To hope is to be imbued with expectation of a good that is yet to be; but at the time of terminal illness it must be sought in precincts where the remission of disease is not to be found. It lives in those other places, awaiting discovery. For the “good that is yet to be” does in fact exist elsewhere and in other forms, even when there is no remedy for the sickness. As a physician or as a person about to lose one who is loved, we can provide hope by a spoken or unspoken promise that this man or woman who puts such trust in us will not be abandoned to die alone; that the meaning of the life soon to end will be perpetuated within our memories and our actions; and that insofar as this can be managed, no suffering will disturb the tranquillity of the final days. Of these three forms of hope, only the last is not always possible to fulfill.

But that is not the end of the story. Dwelling only on the obstacles to providing physical and emotional comfort may lead to medical complacency or philosophical fatalism. For the relief of suffering *is* possible far more often than many of those who attempt to influence public opinion have realized or been willing to admit. The methods of palliative care, or comfort care, have in the past few decades reached a level of effectiveness such that suffering thought at first to be intractable can almost always be relieved. And this is the ultimate message of this vastly important book that now makes its timely appearance, in which are included essays by some of the most prominent names in the movement to oppose physician-assisted suicide and euthanasia.

Like the underlying theme of all medical care, the book’s message is hope. It is a form of hope that will leave some readers—myself included—incompletely convinced; but it is a hope so well articulated in the writings of these authors that this book will long stand as the definitive counter-argument to the wild-eyed Kevorkians and the impatient Hemlockers. More important, it addresses and in specific ways corrects some of the most basic assumptions of the majority of voters in Oregon and the deeply committed right-to-die physicians, lawyers, and ethicists whose lead they followed in passing ORS 127.800-897, the presumptuously named Death With Dignity Act. *The Case Against Assisted Suicide* is certain to change plenty of minds, and some of them will be in Oregon.

About half a dozen years ago, I heard a vague reference to a description of hope by Václav Havel that seemed so appropriate for the situation in which the dying and their families—and their attending physicians as well—so

often find themselves that I determined to discover the precise words that the writer had used. None of the well-read colleagues whom I consulted was able to provide the statement's source, until one day I chanced to use it in the presence of Kathleen Foley, a professor of neurology, neuroscience, and clinical pharmacology at the Weill Medical College of Cornell University. Dr. Foley directed me to an essay in Havel's book *Disturbing the Peace*:

Hope is definitely not the same thing as optimism. It is not the conviction that something will turn out well, but the certainty that something makes sense, no matter how it turns out.

It is no accident that Kathleen Foley alone, of all those whom I consulted, was so familiar with this passage that she could unerringly lead me to its source. The search for "something that makes sense" when therapeutic triumph becomes an impossible goal is the stuff of her career and the mission to which she has dedicated her life. As an attending physician on the Pain and Palliative Care Service at New York's Memorial Sloan-Kettering Cancer Center, she has achieved renown as one of medicine's foremost experts on end-of-life issues. Hers is also one of medicine's most prominent voices in the contentious debate about just what it is that makes sense when a suffering patient asks for help in dying: she is a vehement opponent of physician-assisted suicide. Whether in her clinical work or as program director of George Soros's Project on Death in America, Foley has long been an outspoken and very articulate leader in the fight against legislation that would enable such programs. And now she and an equally authoritative colleague, Dr. Herbert Hendin, medical director of the American Foundation for Suicide Prevention, have brought together a group of like-minded and highly respected colleagues to join them in the crusade. On the list of contributors are names familiar to veteran observers of the fray: Leon Kass, Edmund Pellegrino, Daniel Callahan, Yale Kamisar, Joanne Lynn, and Cicely Saunders. Together with somewhat less prominent authors, they make up a formidable team, and a very persuasive one.

As a longtime participant in the battle (one of the contributors to this book refers to me as "an American euthanasia proponent," and he has it somewhat right), I was reassured to note the title of the introduction that Foley and Hendin have written for their volume: "A Medical, Ethical, Legal, and Psychosocial Perspective." Though several of the contributors to this book are well-known to have strong religious backgrounds and commitments, there is precious little moralizing here, and there is no appeal to any emotion arising from doctrines or dogmas of faith. The emphasis throughout is on facts, data, logic, and a powerful conviction about public and private consequences.

If there is zealotry in these pages, it is in the cause of benefiting the sick, their families, and the larger society. Responsible members of the opposition who read this book cannot help but admire what its contributors have accomplished. I suspect that the most skilled and thoughtful of them will respond with an equally impressive volume of rejoinder.

II.

Throughout the long history of medicine, physicians have always sought to distinguish between those sicknesses that can be successfully addressed by their ministrations and those that cannot be so addressed. One of the proudest attributes of the healer during the era of Hippocrates was his ability to prognosticate, because it allowed him to withdraw when he saw that death would be the certain outcome of the natural process that he had been summoned to treat. For more than two millennia thereafter, the doctor was rarely present at the bedside of his dying patient, whose care was left to the devotion of family and clergy. It was not until the late nineteenth century, after morphine had been synthesized (1816) and hypodermic syringes had been invented (1860), that the physician began to appear in the sickroom of the terminally ill, when he could actually do something of value to relieve the suffering of his dying patient.

The medical profession, as it always had, recognized the onset of certain kinds of symptoms as a signal that continuing efforts to cure would be fruitless or even cruel, and that the time had come to provide comfort. A medical dictionary from 1874 defines euthanasia as "an easy death." An easy death was the goal of every patient and every doctor. But the advent of modern biomedicine would change all of that. With the introduction of therapeutic agents and technologies that sometimes figuratively snatched patients from the edge of the grave, the doctor became a heroic figure of almost mythic proportions. The very same symptoms that a century earlier had been the signal to palliate now became the catalytic factors that stimulated even further the high-energy struggle of yet one more attempt at defeating the implacable enemy.

Doctors, once so skilled in easing death, now focused their biotech abilities on the more dramatic effort of saving lives that were all but lost. The healer's pastoral role was forgotten, replaced by the image of a warrior riding into battle. Dr. Kildare metamorphosed into the embattled star of *ER*. And many lives have indeed been saved. The constantly falling mortality statistics are a source of great and justified pride for doctors and of healthy longevity for patients. And yet something has been lost. What has been lost is the ability, or perhaps the will, to recognize when to stop, and to provide an easy death when stopping is the only thing that makes the sense that Havel

defines as hope. Too often, the struggle to prolong life has only resulted in the prolongation of dying.

Even the word "euthanasia" has come to mean something different from before, and it is not something pretty to contemplate. Foley and Hendin quite rightly point out that were the medical profession better at implementing the word's old meaning, we would hear fewer calls for it to be applied in its new meaning. The know-how is available, but too many physicians do not know how. As Dame Cicely Saunders, the founder of the hospice movement, puts it in her contribution to this book, "The old methods of care and caring must be rediscovered."

The old methods include compassion, which has never entirely left the arena, though it often becomes submerged beneath the onrushing flood of dramatic rescue. In fact, it is compassion that is one of the two foundation stones on which proponents of assisted suicide and euthanasia build the imposing edifice of their case. The other is something new: self-determination, the *cri de guerre* that drowns out the protestations of friends and relatives whose lives are affected by decisions made in the name of an autonomous will, without regard for the needs of those left behind. Like hope, these nouns—compassion, self-determination—are interpretable in various ways, and it is a strength of this sobering book that it addresses the glibness with which they have been used. Under close scrutiny, neither the something old nor the something new supports the conclusions that it is claimed to validate.

Leon Kass ably states the argument of the self-determinationists and his response to it, which is reiterated and verified by clinical observations, surveys, case reports, studies of the pertinent literature, statements by participants, and data that are to be found in various chapters of *The Case Against Assisted Suicide*:

[Its advocates state that] the request for assistance in death is to be honored because it is freely made by the one whose life it is, and who, for one reason or another, cannot commit suicide alone. But this too is fraught with difficulty: How free or informed is a choice made under debilitated conditions? Can consent long in advance be sufficiently informed about all the particular circumstances that it is meant prospectively to cover? And in any case, are not such choices easily and subtly manipulated, especially in those who are vulnerable?

Truth to tell, the ideal of rational autonomy, so beloved of bioethicists and legal theorists, rarely obtains in actual medical practice. Illness invariably means dependence, and dependence means relying for advice on physician and family. This is especially true of those who are seriously or terminally ill, where there is frequently also depression or diminished mental capacity that clouds one's judgment or weakens one's resolve. With patients thus reduced—helpless in action and ambivalent about life—someone who might benefit from their death need not proceed by overt coercion. Rather, requests for assisted suicide can and will be subtly engineered.

Every physician and every nurse who has spent long hours at the bedsides

of dying patients knows that Kass's description of their common inability to make rational or consistent decisions is accurate. These experienced witnesses know also that choices made in previous circumstances, when they seemed proper and wise, are often changed in the face of the reality of grimmer circumstances. A very sick person is not the same man or woman who months or years earlier calmly signed an advance directive or described for closest relatives and a trusted doctor the point at which they should desist from further efforts to maintain life. Family members and caregivers—including the putatively distanced doctors—have goals and agendas that not infrequently confuse what is best for the wavering patient with what is in fact best for themselves.

That much of this understanding is below the level of actual awareness, that much of it proceeds from the best of intentions, does not make it less influential on the minds of the sick. Unknowing coercion is as effective, if not more so, than that which is deliberate. Add to this the well-known fact that the most common reason given by people asking for assisted suicide is not pain or some other specific form of suffering, but their wish not to be a burden to those whom they love. In this way, sometimes unwittingly and sometimes deliberately, loved ones too often influence the decisions of the debilitated and needful.

And the dying are not the only ones vulnerable to the verbalized and silent guidance, expectations, and benefit of others. So, too, are the elderly, the frail, the disabled, the economically disadvantaged. The term "duty to die" has been bandied about, and not in idle conversation but as a consideration in social policy. Following a presentation of my own views on euthanasia at a symposium organized in 1997 by a society of Harvard medical students, I was confronted by a woman in a wheelchair who had positioned herself near the rostrum. She expressed her certainty that people such as herself have a great deal to fear should enabling legislation become acceptable. I thought that she was overstating her case, but I should have known better. Sitting in the audience was a previous speaker, Derek Humphry, the founder of the Hemlock Society and author of *Final Exit*, the best-selling how-to book for would-be suicides.

In the following year, Humphry and a co-author would publish yet another of the polemics that have marked his tireless campaign in the name of self-determination and compassion. This one was called *Freedom to Die*. Here is what the book says about these matters. Read it and think about coercion.

As technology advances, as medical costs skyrocket out of control, as chronic diseases predominate, as the projected rate of the 85-and-older population accelerates, as managed care seeks to cut costs, and as Medicare is predicted to go bankrupt by 2007, the pressures of cost containment provide impetus, whether openly acknowledged or not, for the practicalities of assisted death. . . . [T]he

right-to-die movement is gaining momentum in response to a legitimate societal problem—the emotional, physical, and economic toll of the dying experience on not only government, employers, hospitals, and insurance companies, but on families as well.

This is terrifying stuff. Where is the vaunted freedom of which Humphry and his sympathizers boast? And where, pray, is the self-determination? Probably in the same hellhole that they occupied in Germany in the 1930s, where such philosophies led to their natural culmination in murder.

If the principle of autonomy can be shown to be a weak argument for assisted suicide and euthanasia, what about compassion? It is surely a merciful act to grant a suffering man or woman the quietus that he or she seeks, when anguish is intolerable and no means can be found to relieve it. The response to such a seemingly straightforward statement lies in the matter of where the seeking is being done. An overly large number of American physicians are untrained in the provision of comfort care, and are not even aware of its easy availability. Their standard for powerlessness in the face of suffering is set very low. They are susceptible to requests for help in dying in situations where their colleagues skilled in palliation would have plenty of hope still to offer. They are, in fact, more likely to be proponents of assisted suicide than such colleagues. As Foley and Hendin point out, "It is not surprising that studies show that the more physicians know about palliative care, the less they favor assisted suicide or euthanasia, while the less they know, the more they favor it. . . . In Oregon, when given any palliative care options, patients were far less likely to choose physician-assisted suicide." And this is true even though few of the involved Oregon physicians knew enough about palliation to describe with any experience the high likelihood of its success or the full range of options available to their patients.

It will come as a surprise to many readers of this book that the vast majority of those who seek help in dying do so not because of present suffering, but to avoid what they project will have to be endured as their disease progresses. In almost all cases, a palliative-care expert has the skills necessary to assure them that the tribulations that they expect, or perhaps those that they have seen others experience, can be prevented.

Such patients have multiple physical and psychosocial symptoms compounded by a substantial degree of existential distress [P]hysicians inadequately equipped to care for those who are dying would substitute physician-assisted suicide for rational, therapeutic, psychological, and social interventions that could enhance the quality of life for dying patients. . . . When a knowledgeable physician addresses the desperation and suffering that underlie the request for assisted suicide and assures patients that he or she will continue to do so until the end of their lives, most patients change their minds, no longer want to hasten death, and are grateful for the time remaining to them. But at this time only a minority receive such care.

That is the real issue, the problem that must be solved before legislatures and society rush toward measures that only perpetuate the conditions under which the anguish of too many terminally ill people remains unresolved, leading them to believe they have no recourse but to end their unhappy lives. Help is in almost all cases possible, if only patients and their doctors were aware of it.

III.

Rather than agitate for more Oregons, proponents of assisted dying would serve the sick far better by pursuing a course of action that would change the culture in which we now treat terminal illness to include better public and professional education in what can nowadays actually be done, and improvements in research to make it even better, and changes to health-care policy introducing reforms to acknowledge and finance the needs of the dying and other at-risk or vulnerable populations.

But, it might be argued, why discourage proponents of assisted dying when we have two great laboratories in which it is being studied, and where the results thus far indicate that the programs being implemented can serve as models of success for the rest of the world? After all, the Dutch have been so pleased with their many years of permitting euthanasia that last month they legalized it. And in our own country, the great fears of a mass migration of would-be suicides along a new Oregon Trail have not materialized, with a total of only ninety patients having availed themselves of the benefits of that state's Death With Dignity Act in the four years of its existence. Surely there is by now plenty of evidence that the concerns of the Foleys and Hendins—that there would be failures of safeguards, deliberate abuses, and slippery slopes—have proven to be unjustified.

Or have they? Hendin, in an exhaustive data-filled chapter whose information comes largely from studies authorized by the government of the Netherlands, presents figures that substantiate the charge made by two Dutch physicians in the *Journal of Medical Ethics* in 1999, that “the so-called strict safeguards laid down by the courts and the Dutch Medical Association . . . had largely failed.” His conclusion:

When, as the 1990 and 1995 studies [supported by the Royal Dutch Medical Association and sponsored by the government] document, 59 percent of Dutch physicians do not report their cases of assisted suicide and euthanasia, when more than 50 percent feel free to suggest euthanasia to their patients, and when 25 percent admit to ending patients' lives without the patient's consent, it is clear that terminally ill patients are not adequately protected.

Among the factors from which they are not adequately protected is the heedlessness of their physicians to other possible ways of relieving distress.

Official sanction for assisted suicide and euthanasia interferes with efforts

to improve care at the end of life. If the Netherlands is a laboratory for anything, it is surely for this depressing discovery (which is supported, not surprisingly, by the findings from Oregon). Palliative medicine has not progressed nearly as far in that country as it has in most Western nations, and facilities are few, as described in a chapter by Dr. Zbigniew Zylicz, the director of a small Dutch hospice. There, using thorough consultation with family doctors, it has been his experience that “nearly all the patients who initially propose assisted suicide change their minds at a later date when reassured by the demonstration of effective care and the promise of nonabandonment.” It will escape no reader’s notice that these sick men and women come from the same population pool who are said to demand help in dying as an expression of their self determination in the permissive atmosphere that has in recent decades been a hallmark of their nation’s culture.

But, it might also be argued, we Americans must certainly be doing better at our own laboratory in Oregon. And that is precisely what I thought—until I read the provocative chapters in *The Case Against Assisted Suicide* that have given me pause in making such an assessment. Impressed with the small number of people who have availed themselves of the law, I had put away my earlier concerns about safeguards that I considered inadequate. Several omissions in the legislation had bothered me: a mandatory requirement for consultation by an expert in palliative care; a mandatory psychiatric consultation (the law requires it only when the attending physician thinks judgment is impaired); a mandatory notification of next of kin. None of these were provisions of the act. But in laying these worries if not entirely to rest, then at least to some ease after several years of watching ORS 127.800-897 in action, I seem to have missed a few things about which Foley and Hendin’s book has enlightened me.

It has also enlightened me about my notion—shared with so many other close observers—that, unlike in the Netherlands, the opportunity for detailed study of every case of assisted suicide in Oregon would in fact serve as the laboratory experiment that so many were proclaiming it would be. It seemed a golden opportunity for objective researchers to answer the many questions and to lift the shades of doubt and accusations of clandestine activity that have for so long hung over this issue. It was widely thought that the United States Supreme Court ruling in 1997—that there is no constitutional right to help in dying—would open the way for individual legislation in each state, creating in effect fifty laboratories in which fifty states would approach the problem each in its own way. Oregon would be the first. The pluralistic approach was expected to lead toward an ideal, and idealized, American solution, and a scientifically based one at that.

Well, it turns out that we have no laboratory, not even one. Invoking patient confidentiality, the Oregon Health Department (OHD) does not ask doctors or families for much information about the cases of assisted suicide that are carried out under its jurisdiction. The information that it does possess, which is in the main epidemiological, is not available for inspection by the public, nor is there any provision for independent researchers to study it. Under present circumstances, the Oregon experience cannot be evaluated as would any other innovation in medical practice, with full disclosure and all participants and data made available for review by experts. In fact, a physician with cause to refuse a request for assisted suicide by a patient who later found a willing doctor is legally forbidden to talk about his or her reasons, in the misappropriated name of confidentiality.

That such situations are common is indicated by the figures available: “[I]n six of the fifteen [assisted-suicide] cases in 1998, and in eighteen of the twenty-seven patients for whom the information is available in 1999, the first physician seen by the patient did not agree to assist in the suicide; none of these physicians was contacted by OHD.” Worse yet, none of them is free to reveal the reasons for refusal. And to whom did these distraught patients turn when they were refused? Though OHD does not ask this question, it was later determined that eleven of those first fifteen patients obtained their legal assent from doctors associated with Compassion in Dying, an advocacy group that moved into the state two weeks after the law was put into effect. Its executive director, Barbara Coombs Lee, has said: “If I get rebuffed by one doctor, I can go to another.”

OHD has published periodic reports, but they would hardly satisfy a critical examiner seeking the sorts of clinical details that are of such importance in the evaluation of any new departure from standard medical practices. In an editorial in *The New England Journal of Medicine* in February 2000 commenting on complications described from the Netherlands (a not-insignificant number, including the fact that 18 percent of reported assisted suicides required the intervention of the involved physicians because the attempt was not going as it should), I noted with barely disguised skepticism that neither of two papers from Oregon in the same issue described any complications at all. This seemed strange, since it might be expected that at least some of these terminally ill and perhaps debilitated men and women would be as unsuccessful as many of the Dutch in their attempts to swallow enough pills to bring death, leading in some cases to untoward events such as vomiting or convulsions, which preclude the tranquil death being sought. After reading this book by Foley and Hendin, I find myself wondering what else is going

unasked and unsaid—or at least unreported—that is of considerable clinical consequence. Dr. N. Gregory Hamilton, providing anecdotal and other evidence that certain problems are unavailable for public scrutiny, has titled his chapter on these matters “Oregon’s Culture of Silence.”

And then there is the issue that lurks like an ever-present shadow over every study of assisted death, namely depression. Notoriously difficult for internists and family physicians to diagnose even when there is no organic disease, its complexities magnify as death approaches. Even psychiatrists find it a challenge. Only 6 percent of those surveyed in Oregon felt very confident, absent a long-term relationship, that they could in a single visit determine whether a patient was competent to make a decision about suicide. And yet the law permits just that. The decision whether to request such psychological consultation is in the hands of the physician to whom the request for death is made (with no requirement that this doctor have any previous knowledge of the patient). This means that a doctor who may never before have met the patient in his or her consulting room or at the bedside (not infrequently, as noted above, recruited by Compassion in Dying, a group dedicated to easing the process) is empowered to decide if psychiatric evaluation is required. And even when done, it is likely to consist of no more than the one visit that 94 percent of Oregon psychiatrists believe to be inadequate for making a judgment. OHD’s reports indicate that only 19 percent of cases were referred for psychiatric consultation in 2000, down from 31 percent in 1998. In the Netherlands, the figure is 3 percent.

This means that large numbers of people are being assisted to their deaths without anyone even attempting to find out whether the underlying reason for their suffering is a treatable depression. In their chapter of this book, the psychiatrists Harvey Chochinov and Leonard Schwartz, well-known for their extensive studies of this issue, point out that clinical depression “is a highly treatable source of suffering among those who are dying.” When the pathological sadness lifts, renewed meaning is found in life, the subjective aspects of suffering diminish, and the last days of the dying individual can be spent in the comforting presence of loved ones.

IV.

So why is a man who is described as “an American euthanasia proponent” (to which I plead guilty, with an explanation) so taken with the arguments of a group of authors whose writings are dedicated to prohibiting physicians from helping their suffering patients die? A part of the answer to this question is inherent in every paragraph of what I have written here. Foley, Hendin, and their colleagues have presented a powerful indictment of physician-as-

sisted suicide and an equally powerful argument that, in all but very few cases, appropriate palliative care will eliminate the reasons for which such requests are made. But it is those “very few cases” about whom, as a bedside clinician for four decades, I worry. I worry about them a great deal.

Again and again in this book, there is the barely noticeable admission that a very small number of people will remain unresponsive to every measure—pharmacological, psychological, sociological, spiritual—directed by the most expert of palliative physicians toward the relief of their anguish. What are we to do for such men and women? Some of them will ask for help in dying. How are we to respond? What is the duty of those of us who are committed to the proposition that the relief of human suffering is an even greater good than is the cure of disease or the prolongation of life?

There is no perfect solution; there may not even be a good solution. Any suggestion or plan will be fraught with uncertainty, with objections from various constituencies, and with difficulties in implementation, not to mention the possibility of error in any individual case. But such is the very nature of caring for the sick that physicians live with far greater uncertainties than this one every day of their professional lives. They often make decisions in the face of an ambiguity that is at times not only clinical but also moral. The field of medical ethics has taken on two sorts of responsibility: to point out directions when they are clear, and to help find the way when they are not clear. It is this latter place, the thicket of doubt and inexactness, in which men and women of good will find themselves in the bioethical conundrums of our time. Help in dying is among the most baffling of them; but this does not mean that we should shrink from trying to find a solution, flawed as it may be, though it is needed only for the minuscule number who cry out for it.

I believe that we should heed their pleas. For those few men and women, it must be required that their repeated requests are made to a physician who has had a long-standing relationship with them; that the consultant chosen by that physician be one whose specialty is in the area of the patient’s disease, to be sure that therapeutic options have been exhausted; that, in that grim event, consultation with a palliative-care expert be mandatory, as well as evaluation by a psychiatrist experienced with patients at the end of life. Since I have witnessed situations in which members of the clergy bring spiritual respite to a person tortured by self-doubt, I enter here the suggestion that even unbelievers be offered the consolation such a visit may sometimes bring.

And then there is the matter of those to be left behind by the chosen death of someone they love. I believe such a choice must be defensible to the few people to whom the dying are closest. It is not so much their assent that I would seek, but their understanding that, in the beloved face at which they

will soon be looking for the last time, they see the relief that such a decision can bring. To support that decision, it is necessary to agree with it. Principles of individual freedom, respect for the humanity of the dying, and, yes, the reality of the individual's moral autonomy demand that it be honored when other options have been explored, in the ways that I have outlined, and have been found wanting.

By granting the right to be given help in dying, a society is commenting on its values. In fact, it comments on its values each and every time that such a right is exercised. If that is so, then society should affirm each and every such decision. And here I offer a suggestion that may seem odd, superfluous, and even antiquated. It is that final consent should be in the hands of a kind of council of elders, people in a community or institution known for their probity, wisdom, and sense of civic responsibility. In some instances, a hospital's bioethics committee could fulfill the purpose, but there might be objection that it serves the interests of the institution. Instead, I would seek out representative members of the community who would convene on the rare occasions when such a thing is necessary. The limits of individual fallibility and the complexities of shared decision-making notwithstanding, such a council might constitute an influential forum deliberating on the moral principles of a period, a place, and a polity of reflective citizens.

For a plan such as this one to have usefulness as a guide for further decision-making, every step of every patient's case must be documented in detail and available for study, as would be the medical record in any other form of clinical research. From time to time, a comprehensive report of the national experience should be made available for public scrutiny, prepared by a panel appointed by a central non-political body such as the Institute of Medicine or the American College of Physicians. Much is yet to be learned.

Should all of this be legislated? Until now, I was convinced that putting matters of such a nature into the hands of politicized officials would be a serious error. I had the perhaps fanciful notion that American medicine and the public might together arrive at a sort of consensus, in which adherents of opposing viewpoints could, realizing that the safeguards in a plan like this would correct the deficiencies of Oregon or the Netherlands, compromise on viewpoints and achieve what might be called common law, the consent of the people. But after reading of all the possibilities for abuse that Foley and Hendin's book describes, I am of two minds. It may be that carefully policed legislation will be the only way to ensure compliance with every element of the plan.

I have twice in this essay noted that the mode of death that I am said by this book to support is euthanasia. The term "assisted suicide" does not appear in

the description of my position. And this is as it should be. Not only does common sense indicate that attempts at suicide made by dispirited, very sick people acting without help are prone to ineffectiveness and complications, but such intuition is borne out by the Dutch reports and by published information from elsewhere as well, when physicians were anonymously polled about their personal experience. The fact that the Oregon Health Department does not mention these mishaps should not be taken as evidence that they do not occur.

Physicians who believe that they have a moral and ethical obligation to provide assistance in dying should do so with the same attention to avoiding untoward events as they pay to all other aspects of medical care. It does not suffice to hand a stricken patient a prescription for barbiturates and instructions for how they should be used, and then presume that all will turn out as planned. If the termination of suffering is the physician's aim, there should be certainty that his or her intervention will not add to the affliction that it is meant to relieve. Physicians so inclined should become skilled in the techniques of euthanasia, or, all of the appropriate confirming steps having been taken, make a referral to someone who has mastered the necessary methods.

These are my proposals, and the contributors to this important volume have made me feel more convinced than ever of their validity. I say of their validity, but not necessarily of their correctness in every case. In extreme situations, extreme measures must sometimes be taken, and those who take extreme measures must be prepared not only for the controversy and the criticism that will ensue, but also for the possibility that they may, in individual cases, be in error. My proposals are susceptible to being shot full of holes, but the holes will surely be smaller in size and number than those so appropriately exposed by Kathleen Foley and Herbert Hendin.

If, as Václav Havel says, hope is the conviction that something makes sense, perhaps it makes sense to relieve, in the way I have described, the terminal suffering of that tiny percentage of desperate men and women who are resistant to even the best efforts at palliation. I suppose that statement does indeed make me "an American euthanasia proponent," but I prefer to think that I am a proponent of hope. "Such is hope," Charles Dickens observed in *Nicholas Nickleby*, "Heaven's own gift to struggling mortals; pervading, like some subtle essence from the skies, all things, both good and bad." Pervading even death.

“Older Children”

Lynette Burrows

This is the only chapter of *Good Children* that has been more or less completely re-written since the second edition came out in 1990. At that time, the whole country was gripped by what might happen as a result of AIDS. Even the government thought that we were all “at risk” and a leaflet was put through the door of every house in the UK, telling people that they would have to be extra careful, regardless of whether they were old, in stable marriages, crippled by illness or decisively celibate, like a nun.

It was absolutely obligatory to mention it in speaking to young people then, since my own children were agog with what was going to happen next. So I spoke about the disease and how the ancient moralities of chastity and fidelity were likely to be some comfort and protection in such a context. The problem then was that no one was sure whether the disease could be spread by more means than simply sexual contact. I went to a parents meeting at one son’s school, where the Headmaster told parents that the joint use of musical instruments might have to be discontinued, and that almost anything used by more than one person might prove to be a danger. My daughter at the Further Education College received a leaflet warning that “deep kissing” might be a source of infection if they had any lesions in the mouth, or gums that occasionally bled.

Thankfully, these fears turned out to be groundless and the disease has confined itself mainly to those who have had contact with the three known high-risk groups which were, and are, homosexuals, hard-drug users and those who contracted the disease abroad, usually in sub-Saharan Africa. Recent figures from the Public Health Authority show that the majority of AIDS cases in Britain are restricted to these groups.

So the debate has moved on, but the problem of infection resulting from what Nature plainly does not like or accept—that is, promiscuous behaviour—has not. We are engaging in a major war with nature if we think we can change this just because of our new technology. In the past, people accepted the limitations of nature because they did not want to be diseased or infertile. Religious people would say that they observed God’s hand in the laws of nature and based their morality on them. Agnostics would say that people

Lynette Burrows is a well-known English educator and journalist. A revised edition of her 1989 book, *Good Children*, will be published this fall by Family Publications, Oxford. “Older Children,” the chapter we reprint here, “has been more or less completely rewritten,” Ms. Burrows tells us. It appears with permission of the publisher and author. © Family Publications 2002.

made the best of a bad job and invented devices like religion and romance to make youthful abstinence more palatable.

Whatever your point of view, the fact remains that, for all our cleverness, 35% of all sexually transmitted diseases are incurable, and are spreading at an alarming rate, particularly amongst the young. In response to this, the authorities are clutching at straws and urging ever-more-sexually-explicit sex education upon children, including an obsessive concentration on the almost magical powers of condoms. Consider this highlighted information contained in a booklet issued by Health Authorities up and down the country:

“FACT: Only condoms provide all-in-one protection against pregnancy and sexually transmitted infections, including HIV.”

This statement is just not true and, what is more, it seems to me to be deliberately misleading. What does “all-in-one” mean here? That it doesn’t come in three pieces that need to be assembled? That there are other devices that have footwear and gloves to accompany them? It is meaningless but it gives an impression of being dependable and risk-free. That is what young people would make of it. That is what many of them *do* make of it.

The matter is therefore urgent and I decided, in this chapter, to follow the agenda that is most often set for me by young people. Since my own children have grown up, I spend a lot of my time giving talks to sixth-form groups and college students, sometimes following up on a recent article or a television programme I have done. Regardless of the title of any of my talks, we always seem to end up talking about what concerns them most—and that is their frightful ignorance about the “facts of life.” They are propagandised in many of their encounters with “Health professionals”—but they are seldom told the truth about another reality that awaits them far more certainly than the ideal of sexual freedom they have been promised.

Many of these groups are quite large, two or three hundred young people, and someone will usually start the questions with something like, “Why do you think so many girls get pregnant then?” There is usually laughter at this point, and I turn the question round:

“Why do *you* think they do? Is it because they have never been told the facts of life, or do you think they didn’t know about condoms?” There is usually quite a thoughtful answer then, because the person knows that his peers are checking the reply against their own experience.

“There’s lots of reasons,” they say. “They might not have done it right, (laughter); they might have been drunk or the condom, you know, like, fell off.”

“So you do think they would have been using a condom then?”

“Yes, of course; everybody knows about safe sex, don’t they? And you

don't just suddenly have sex; do you?—unless you're a bit of a slapper. I mean, you know it's going to happen, she's probably your girlfriend at the time, so you take a condom."

"So what goes wrong? Do you think they are just inexperienced and put it on their head by mistake? Haven't they been shown what to do with it?"

"Yeah, they know what to do with it. Blimey! We've had so many lessons about that . . . they'd be stupid if they didn't." (more laughter) "All right, you tell us why, *you think*, they get pregnant then."

"Well, I would have thought it might have something to do with the failure rate of condoms, don't you?"

That is the first bombshell! They often howl with laughter at that point and shout out, "Haven't you ever heard, *it's safe!*" They invariably turn to look at whichever teacher is responsible for "Health Education" at this point—if she is in the hall—and this lady generally nods sagely in agreement.

So I point out that even the contraceptive manufacturers concede that there is a failure rate for their products in practice and that it is about 15% for married couples and a good deal higher for people of their age. "Some researchers have found it to be as high as 40%, but let us take a lower figure and say that it is about 20%. That still means that if there were one hundred girls in this room who all used condoms at all times, about twenty of them would get pregnant. In other words, there is a one-in-five chance of getting pregnant—roughly the same odds as Russian Roulette!" This is a useful analogy because anyone can see that you would not shoot yourself every time. Other things have to be factored in when calculating how soon you *would* shoot yourself.

The young people are incredulous and disbelieving. At one talk, they even appealed to the teacher to refute me but, since I always carry the relevant statistics in a folder with me, she didn't argue and I was interested in her obviously sincere answer. She said that she was well aware that condoms had a failure rate but didn't over-stress it. Since young people could not be restrained from "having sex," it was her responsibility to see that they at least lessened their chance of getting pregnant by using a condom.

It is a common point of view; but doesn't one usually mention the risk factors inherent in any dangerous activity, and then leave the participants to make up their own minds about whether it is worth it? The fact is, most young people don't know about the dangers of what is often a fairly experimental, rather than a deeply felt, foray into sexual experience.

At a meeting at Cambridge University, I asked a group, "What do you think 'Safer Sex' means? Safer than what?" Their answer was so interesting

that I have asked it many times since and the result is always the same. About half of any group think it means, “safer than nothing at all.” The other half thinks it means, “safer than safe.” As they often say, “You were safe before, but this one is even safer than that! Man, are you safe now!”

I tell them that the answer is, of course, safer than nothing—which is exactly what condoms are. Then I ask them why they think this product is labelled in this way and, after thinking about it—usually for the first time—they say that probably it is because they could be sued if they claimed a thing was “Safe” when, in practice, it wasn’t.

I agree with them and do not believe that it is just happy chance that the condom industry has stumbled upon a form of words that is ambiguous to most young people. It encourages them to use it, in the belief that they are, indeed, “safe.”

This pattern of misleading young people—for their own benefit, supposedly—has extended, even more crucially, into the way the government health authorities are handling information about sexually transmitted diseases (STDs). The same booklet that I mentioned before contains the information that “many young people do not know about STDs.” Having said that, the booklet then says nothing whatever about most of them—except for two things. They have the following, prominently highlighted information: “Factoid: Up to one in fourteen young people have an STD called chlamydia, often it shows no symptoms but, if left untreated it can leave 10-15% of sufferers infertile. Always use a condom.”

Now doesn’t that suggest that if they use a condom, they won’t catch it? I think it does, otherwise why mention condoms at all? But they know this is untrue and the fact is often mentioned, in muted tones lest it offend anyone, in the medical pages of newspapers. In fact, “one in fourteen” young people sounds quite small, doesn’t it? It doesn’t sound as alarming as “hundreds of thousands” anyway.

The most definitive study we have was conducted by the prestigious and dependable National Institutes of Health in the United States, which published a report in July 2001 in which it reviewed all the published literature on the subject of condom effectiveness to date. It found that “there is no clear evidence that condoms reduce the risk of *most sexually transmitted diseases, including gonorrhoea and chlamydia*” (my italics).

Just think about that for a minute will you? There is nothing to show that condoms reduce the risk of catching an STD. So why are we telling teenagers—who are, according to government figures, the most vulnerable to acute STD infection—that they will be “safe” if they use one? Young people obviously fear STDs yet, instead of telling teenagers about them plainly

and with some of the graphic precision that they bestow on other areas of sex education, the Health Authorities seem to be doing everything they can to leave them in ignorance.

Here is another pearl of wisdom from an ubiquitous advice booklet, issued in this case by Cornwall and the Isles of Scilly: "Many young people today are not fully aware of the risks of HIV and other sexually transmitted infections. *If you are worried that you may have been in contact with a sexually transmitted disease through unprotected sex . . . then you can go for free, confidential, anonymous tests at the Dept. of Medicine.*"

In what other field, dear readers, will you be warned about a dangerous activity by being told where you go to get help *after* you've got hurt, but nothing else. They just avoid the issue.

They certainly are not telling them that condoms offer little protection against STDs, nor that they are a growing menace. I have not seen one booklet which mentions that STD infections doubled from 1990 to 1999 and that, in that year, they stood at 1,170,000 and are still rising in great leaps. In other words, they give young people no idea of what their chances are of catching a disease by means of sexual activity.

I recently gave a talk to teenagers and their parents in a small town in a sparsely populated part of the country. The figures I had obtained about STDs there, showed that they had more than 400 cases of Human Papilloma Virus in just 3 small towns in the area. This is the most common STD in Britain and is incurable. It produces unsightly warts in the genital area. It can respond to long and uncomfortable treatment, but the virus is there for life. The American National Institute for Health Report said that it was responsible for 98% of cervical cancers in women. The report also said that condoms have "*no impact*" on the spread of this disease, which can thus be passed on at every sexual encounter, with or without a condom.

This is startling, isn't it? And yet no mention is made of this—let alone the implications of it—in the booklet or in the information produced by the local Health Authority. They simply ignore it as if it will go away rather than go on spreading.

The reason I think this is wrong in itself and potentially disastrous is that, at about the time the original AIDS "scare" was filling the media, some people began to voice concern about what was happening in Africa. We had a medical student living with us at the time and he did his probationary year in Africa so we got it from the horse's mouth, so to speak. He told us that medical opinion there believed that *if* the spread of AIDS followed the level of STDs in Africa, there would be an epidemic of the disease in that country. Well it

did, and now they have catastrophic numbers of people sick and dying of the disease, and still no solution in sight.

The reason for the original speculation was that it was always suspected that the spread of HIV was related to venereal infections which cause lesions in the reproductive organs and it is these which facilitate the entry of the HIV virus into the bodies of heterosexual men and women, who are outside the usual risk groups. Once it got into the heterosexual population, then it would spread like wild-fire. Any country, therefore, ought to be taking a great deal of notice of any increase in STDs, particularly in young people.

In the UK we know that the official "risk" of catching HIV is 1%, but that is because it is not yet widespread in the general population. The American National Institute figures for condom efficiency against HIV infection is 87%; that is, they have a 13% failure rate in laboratory conditions and if the condoms are in perfect condition. Even so, it seems to me to be wicked to promote, in Africa, the use of something that will cause 13 people to die out of every 100 who use it during sex with an infected person.

However, in practice, the situation is even worse. A study among prostitutes in Kenya found a 33% infection rate amongst those who always used a condom.¹ This is roughly the same as that found amongst HIV-infected young people by Dr. Margaret Obola in the Cottolenga hospital. "The disbelief and shock in the reaction of young people when they are told they have AIDS is heartbreaking;—'But it was SAFE sex,' they tell me," she said.

Quite so; but we are ensuring the same habitual ignorance here and, furthermore, we are perpetuating the myth that young people are incapable of restraining themselves in sexual matters, even if they were to know that it might be fatal.

One final reference to the American Report—that seems to have sunk without trace here—is that the President of the Medical Institute for Sexual Health, who contributed to the Report, said this: "All future sex education programmes must reflect the information that is consistent with the Report's findings, otherwise the programme should be considered '*medically inaccurate*.'"

Well, I've asked the question so I might as well try and answer it. Why do the relevant authorities mislead young people in this way? The answer is, I think, because they have a certain way of looking at things. So many of those who work in the area of sex education come from the Family Planning Association (FPA) and its off-shoots and they are, and I don't suppose they would disagree, "contraceptive-minded."

As a matter of fact, they also have what some would see as a financial interest in *not* discouraging sex. The Brook Advisory Centres were set up by

the FPA in 1964 and were, at first, funded by the FPA. Some of the joint directors of these companies then formed a separate company in 1972, Family Planning Sales Ltd. The interesting thing is that the *surplus profits* from this company are covenanted back to the FPA. In other words, the FPA does have a financial interest in the selling of condoms. In any other, similarly controversial area—such as smoking or drugs—the media are hot-foot after any conflict of interest. Why is it only in this area that they have gone in for a “willing suspension of disbelief”?

However, it is seldom simply commerce that has the power to drive along a great band-wagon like that of liberal sex. That is where ideology comes in. After all, what are the logical consequences of having to accept that casual sex—of the sort we see all the time on the television and in every other medium—is actually dangerous to health in a serious way?

The “chattering classes” have given their unconditional support to the sexual revolution that is producing so many young, hapless casualties. These are often the same people who scan tins of vegetables to see if there are minute traces of something that might knock ten minutes off their life expectancy; and who complain if someone lights a cigarette in the same building as themselves. How can they face having their most cherished life-style option branded as “dangerous”; even “deadly”?

It would be the death of all their dearest fantasies and would involve having to concede that religion had grasped more of the truth about real life than they had. In short, they just cannot bring themselves to say that we may have to accept that the price of sexual freedom is too high; for the individual and for society.

Fortunately for our survival as a society, however, there is a growing movement that does not have this horror of nature’s way. They are young, enthusiastic, and they are the driving force behind the programmes of abstinence education that are currently making such progress in the USA. They have reclaimed chastity for the young as their birthright and they are not a bit embarrassed about it.

Various “spokespersons” for the sex-education lobby have, predictably, tried to rubbish this movement, even though they seem to know nothing whatever about it. But distinguished commentators like Melanie Phillips² have taken the trouble to go to America and to judge for themselves how it is working and what is the effect. It has been, for the most part, a well-documented, thumping success and their government is now vigorously supporting it, even financially. It has been effective in lowering illegitimacy and disease, sometimes dramatically, whilst in many cases increasing the

educational achievement of the most disadvantaged pupils well beyond what most people expected.

These abstinence programmes work because they are imaginative, new and exceptionally well thought out. One of the many initiatives used in this new way of educating children in abstinence rather than sex, is the use of young people, usually students, who go round schools to demonstrate a positive view of chastity. They use sketches and quick-fire games to demonstrate typical situations in which young people find themselves. They are often very funny, as when they demonstrate “ten ways of saying No”; and reproduce some of the cheesy “chat-up” lines that are current. They are also touching in their personal experiences of being used and discarded, and of the fear and worry that blights the lives of those who have got caught up in an often unwanted sexual merry-go-round.

They are not embarrassed by virginity but treat it as an asset that demonstrates personal autonomy. It is a part of their youth and they want to treat it as special. The ensuing freedom from anxiety is shown to be worth more than keeping up with the sexual Joneses of their peer group.

Until I saw one such group, “Challenge” from Canada,³ giving their presentation on a tour of schools in England this year, I would not have believed it possible to be so up-beat on the subject. In fact, the contrast with the typical sex-education professional could not be more marked. For a start, they are unpaid and do it because they believe in it enough to subsidise their trips out of their own pockets. They are also at the start of their lives and full of the energy and “can-do” optimism that often goes with that. They also do not use crudity as a means of establishing their credentials to talk on this subject. None of the young people in their audiences needs cringe with embarrassment at graphic descriptions and crude, mechanical scenarios. We can only hope and pray that abstinence education faces down its critics and becomes the norm here too.

In fact when you think about it, in the context of what young people are really like, what appeal is there in the idea of having a penis in the middle of a board game; or huge black and white drawings of genitalia to pass around a mixed group in order to teach them—what? How to be crude, how to overcome any feelings of delicacy or modesty? It associates the subject entirely with lust, ugliness, and—oh, yes, “Don’t forget to buy those condoms now, will you?” That’s always the end result of any lesson—don’t forget the product it is promoting.

No wonder some young people have rebelled against it, and no wonder their current dreary, middle-aged sex-educators—who try so hard to appear “with it”—fear having the whole thing taken out of their hands and given

back to this new generation, whose lives are still in front of them.

Since this chapter follows on from the one about sex education, you may well ask whether it alters anything I said there. The answer is, no, but there is a rider. Children today sometimes need to be protected from those in authority. It was only in January, 2002 that public pressure from parents forced the Scottish authorities to withdraw sex-education material that was quite plainly obscene from their schools. People who talk graphic sex to children in any context outside the family, should be treated with suspicion and may be suffering from paedophilic tendencies. Parents would be wise, therefore, to protest forcefully if any material comes into the classroom that would be seen as abusive if it were presented to their children in any other context.

Actually, if one considers the effect of the government actually deciding to promote chastity in schools, one can see how enormous the changes would have to be and how total the shift of emphasis. When looked at from that point of view, one can clearly see just how propagandistic current sex education is. Good heavens; can you imagine trying to discourage football hooliganism by showing films and photos of young men battling with one another? Close-ups and examples of the weapons they use and scenarios of how a fight might start; the “cool” armour they could don in the heat of battle; all bullet-proof, of course. Plus, of course, absolutely no mention of either the nature or the number of the injuries inflicted, the cost to society and, certainly no interviews with casualties. Would *anybody* seriously think this was the way to do it?

The root of the problem is that the people who are currently in charge of sex education are not basically in favour of young people abstaining from sex. In its Annual Report 2001 the Brook Advisory Centres describe their mission as: “Equipping young people to enjoy their sexuality without harm.” Unfortunately, they cannot deliver the one without the other, except by chance.

If only that “mission statement” had read, “Helping young people to enjoy their *youth* without harm,” how much more suitable it would have been. But then, it wouldn’t have included the obligatory reference to the “equipment” they provide and the clinic would probably have no reason to exist.

My own family is Christian, so chastity before marriage, and fidelity within it, have always been accepted as normal and natural, despite the odd backsliding relation or two. Neither does it seem to have been too onerous. In many respects the young actually have less need of sexual intercourse to animate their relationships than almost any other adult age group. With their extravagant emotions and acute, obsessive perceptions they have a feast of enjoyment from one another without the necessity of fornication. Of course sexual attraction is the basis of a lot of their behaviour, but how that attraction

is deployed in their own interests is crucial. I do believe that they need to beware of being *seduced* by their culture into abandoning their natural inhibitions, which are, after all, there to protect them—their feelings, their self-respect and their health, now and in the future.

The problem is that romance is a crusading ideal and not just a sloppy emotion. It is a serious philosophy which believes in the seminal value of passion, properly harnessed for the good of all. As such it needs to be passionately and seriously expressed, as it was when it first swept Europe in the thirteenth century, by troubadours travelling from place to place spreading its message and gaining converts to a new, much more interesting way of seeing the relationship between the sexes, that was called “romance.”

Their eloquence started a romantic tradition that lasted until the beginning of the permissive age and the marketing of sex as a commodity that has reduced almost every kind of relationship to a simply sexual one.

If the will is there, it could be rescued by that modern equivalent of the troubadour—the mass media—and restored to its former importance. As a tradition, it has never lost its appeal to the imagination; and romance, both in the classics *and* in popular culture, is as sought after today as ever it was.

The return of an ideal of unconsummated sex in youth might have another fundamental effect apart from its role in limiting the spread of misery and disease. It could help reduce the number of divorces by returning the *courtship behaviour* of young people to something akin to its true nature.

The 1960s were a great period of social change and many old laws and traditional practices were abandoned in the name of progress and improvement. Many of them have produced results that are quite contrary to what the advocates for change originally envisaged, and nowadays we can hardly remember the reasoning behind some of their theories.

One such perverse improvement was the idea that if a couple lived together before getting married, then there would be fewer mistakes in choosing a permanent mate and, hence, less divorce. Now however, official statistics confirm that marriages contracted after a couple have lived together first break up more quickly and more often than other marriages. The intriguing question is why; and the answer is, I believe, relevant to the foregoing remarks about romance.

Romance is a sort of courtship ritual transformed into an art. The art, though highly artificial, nevertheless only disguises a process that is even found in some animal behaviour, where it serves a strictly practical purpose associated with the survival of the species. Its function in those animals where it features is largely to provide *time* for the male to demonstrate his skills as

a provider of food and shelter and his devotion and fortitude as a protector of the female and her young. The female needs the time to decide whether he fits her instinctive criteria. She then consents to mating and, a pattern of co-operation having been established, they stay together to raise the young.

This *natural* need for a relatively uncommitted period of assessment between people, to establish intimacy and knowledge before they get married, is what we have ignored in our recent culture. We have failed to grasp that the function of courtship is to establish compatibility before the commitment of marriage. We haven't noticed that consummated sex is important after marriage for precisely the same reason that it is counter-productive before it.

After marriage, a new sexual relationship is important because it has the power to blind the parties to the inevitable difficulties of adjustment to a situation where, however desired it is, there is a certain loss of independence and "sovereignty." It cements a relationship in the face of those aspects of it which at first do not work very well and it makes bearable the sometimes painful process of two people growing together. "Making love" is a literal description of what takes place in a fully consummated act, and the time for that is *after* deciding, more coolly, that you are genuinely compatible.

This blinding power of sex which is such a help within marriage is, however, disastrous when you are *choosing* a mate. You do not want it to cloud your judgement and disguise major differences when you are getting to know someone. You cannot afford to be swept away in a sea of emotion at a time when you should be assessing more deliberately those qualities of character and temperament you will need to last a lifetime.

When talking about marriage rather than casual affairs, sexual intercourse has always been described as a consummation. That is, the culmination of a ritual and not just part of a journey. This ritual, which we call romance, most likely served as a vehicle for minimising mistakes at a time when men and women were becoming more free to choose their mate than they had been previously when the choice had been made largely by their families.

In departing from the time-honoured practice of a sexually unconsummated period of courtship, we have bequeathed to our children an unworkable strategy for choosing a mate that has caused immense suffering to couples and to their children, who lose one of the people they love most in the world when their parents separate.

There is another aspect of cohabitation that I would not have thought of myself if friends of my children had not mentioned it to me. It concerns the difficulty that some couples have—particularly the young men, I must say—in deciding whether to turn cohabitation into marriage. They live together, so they share all the advantages of the married state; they have intimacy,

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companionship and mutual help. They are also free. Mentally, psychologically and legally, they can “walk out” at any time without too much hassle.

When they come to contemplate getting married, therefore, the married state is at a disadvantage. It offers no more than cohabitation and it is loaded with responsibilities and expectations. I have on several occasions comforted a weeping girl who has spent several years living with a young man until she felt ready to settle down and have children. Then she found, to her great grief, that he was not willing to marry her. In the shock of discovering that this person whom she felt was her friend and soul-mate could treat her so badly, she left the home they shared, only to hear a short time later that he had married someone else.

This is quite a common scenario and a heart-breaking one, particularly if it is the girl who is ditched. She has a much shorter time in which to have her family before nature makes it difficult to conceive, and no amount of “equal opportunities” has altered the fact that a man in his late thirties is still considered quite eligible, whilst a woman is usually not.

Maybe it is the unacknowledged recognition of this fact that makes women, if they are sensible, take marriage very seriously. Let us just say then, that it does not take “true love” to make a man live with you—which is probably why only 4% of cohabitees stay together for even ten years, with or without children. Marriage is the test and, despite any impression to the contrary, a big majority of them do last.⁴

NOTES

1. N. Nzila, M. Laga, M. Kivuvu, R. Ryder: Evaluation of condom utilization . . . among prostitutes in Kinshasa, 1989.
2. America's Social Revolution by Melanie Phillips, Civitas, 2001.
3. The “Challenge” team can be contacted by e-mail at: challengeteam@comnet.ca.
4. “Less than four per cent of cohabitations last for ten years or more.” [Cohabitation in Great Britain, Ermisch & Francesconi, Institute for Social and Economic Research, 1995].

APPENDIX A

[The following is the text of the White House transcript of remarks made by President George W. Bush at the signing of H.R. 2175, the Born-Alive Infants Protection Act, at the Pittsburgh Hilton, Pittsburgh, Pennsylvania, on August 5, 2002.]

President Signs Born-Alive Infants Protection Act

George W. Bush

12:58 P.M. EDT

THE PRESIDENT: Well, thank you all very much for this bill signing ceremony. I'm pleased to sign it in the great city of Pittsburgh, Pennsylvania. The history of our country is the story of a promise, a promise of life and liberty made at our founding and fulfilled over the centuries in our laws. It is a story of expanding inclusion and protection for the ignored and the weak and the powerless. And now we extend the promise and protection to the most vulnerable members of our society.

Today I sign the Born Alive Infants Protection Act. This important legislation ensures that every infant born alive—including an infant who survives an abortion procedure—is considered a person under federal law. (Applause.) This reform was passed with the overwhelming support of both political parties, and it is about to become the law of the land.

I appreciate so very much Senator Rick Santorum and Congressman Steve Chabot from Ohio for sponsoring this important piece of legislation. I also appreciate Senator Arlen Specter of Pennsylvania and Congresswoman Melissa Hart for coming, as well. I want to thank the Bishop of the Diocese of Pittsburgh, Bishop Wuerl, for being here. It's good to see you again, Bishop. I appreciate Hadley Arkes, the Professor of Jurisprudence and American Institutions at Amherst University. I want to thank Jill Stanek, registered nurse, Labor and Delivery Unit, Christ Hospital and Medical Center, for being here, as well. I appreciate Gianna Jessen, who is an abortion survivor and a pro-life advocate. I want to thank Dr. Watson Bowes, who is a Professor Emeritus of Gynecology and Obstetrics at the University of North Carolina.

I want to thank you all for coming. It's important that you're here, to send a signal that you're dedicated to the protection of human life. The issue of abortion divides Americans, no question about it. Yet today we stand on common ground. The Born Alive Infants Protection Act establishes a principle in American law and American conscience: there is no right to destroy a child who has been born alive. (Applause.) A child who is born has intrinsic worth and must have the full protection of our laws.

Today, through sonograms and other technology, we can clearly—see clearly that unborn children are members of the human family, as well. (Applause.) They reflect our image, and they are created in God's own image.

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The Born Alive Infants Protection Act is a step toward the day when every child is welcomed in life and protected in law. (Applause.) It is a step toward the day when the promises of the Declaration of Independence will apply to everyone, not just those with the voice and power to defend their rights. This law is a step toward the day when America fully becomes, in the words of Pope John Paul II, “a hospitable, a welcoming culture.”

Our society has enough compassion, wealth and love to care for mothers and their children, and to see the promise and potential of every life. In protecting the vulnerable and the weak, the imperfect and the unwanted, you are affirming a culture of life.

I’m grateful for your perseverance on behalf of this noble cause. I want to thank you for your hard work. I appreciate your care for every member of the human family. Thank you for coming today. It’s now my honor and pleasure to sign into law the Born Alive Infants Protection Act. (Applause.)

(The act is signed.) (Applause.)

END 1:04 P.M. EDT



APPENDIX B

[Gilbert Meilaender is a member of the President's Council on Bioethics. The views expressed here (reprinted from 8/26 issue of The Weekly Standard) are his own and do not represent the council. © Copyright 2002, News Corporation, Weekly Standard, All Rights Reserved.]

Spare Embryos

Gilbert Meilaender

In our ongoing debate about the use of human embryonic stem cells for research, there is one compromise position that reappears with regularity and attracts relatively wide support. This position proscribes (at least for federal funding) any research on stem cells derived from embryos produced solely for research purposes, while permitting research on stem cells derived from embryos that were produced but are no longer needed for use in infertility treatments. (I am not here referring to a different sort of compromise struck by President Bush in his speech of August 2001. He permitted funding for research on embryonic stem cell lines only if the evil deed of embryo destruction had already been done but not for cell lines derived from embryos destroyed in the future—thereby seeking to permit some research to go forward without providing an incentive for further destruction of embryos.) Because spare embryos are destined to be discarded in any case—because, that is, the decision of those with legal authority over the embryos has been to discard them—they have no future life prospects. They are destined to die, and the only question is how. Why not, one might wonder, gain some useful knowledge from their dying?

This compromise approach is not without appeal, and it has a distinguished pedigree. It was, for example, specifically endorsed by the National Bioethics Advisory Commission in its 1999 report on “Ethical Issues in Human Stem Cell Research.” The commission recommended that research on stem cells derived from spare embryos remaining after infertility treatments be eligible for federal funding but that, at least for the present, such funding not be permitted for research on stem cells derived from embryos that had been produced solely for research purposes.

This is a thoughtful compromise and in certain ways attractive. At the very least, it seems less crass than simply endorsing embryo research without limits. Perhaps some support the compromise solely for strategic reasons—as a first step but not, they hope, the last step in embryo research. But for others it may demonstrate a praiseworthy inclination to “shudder” just a bit in the face of a routinized use of nascent human life that any full-fledged program of embryo research would certainly involve. Nevertheless, appealing as this mediating position is in certain respects, we should not too quickly endorse it; for the pedigree of this sort of reasoning is actually more mixed and troubling than we usually realize. Consider the following three examples:

In the mid-1970s Congress established a National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. This commission, which proved to be fairly influential, examined and issued reports on a num-

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ber of difficult topics in the ethics of human experimentation. The first of its reports, issued in 1975, was "Research on the Fetus." With certain safeguards, the commission was prepared to approve research on the fetus *in utero* and on the possibly viable infant outside the uterus, but if the research was not aimed at benefiting the research subject himself or herself, the commission required that it impose "minimal or no risk" or "no additional risk" to the well-being of the fetus or infant.

Having agreed on that, the commission also had to consider possible research on the fetus still living in the womb *but intended for abortion* (that is, destined to die) or on the child still living outside the womb after abortion *but nonviable* (and, hence, destined to die). The commission eventually recommended that these possible research subjects be given equal treatment. They too should not be subjected to research that imposed more than minimal risk or any additional risk to their well-being. It is instructive, however, to remind ourselves that several of the commissioners argued that "equal respect" could mean something quite different for a fetus-to-be-aborted or for a still living but nonviable child outside the womb after abortion. In those cases, these commissioners suggested, one cannot impose any additional risk of harm or further diminish the life prospects of these potential research subjects. They are going to die; the only question is how. They may simply die, or they may be used as research subjects in the course of their dying. In the latter case, so the argument went, we do not treat them unequally or respect their lives less. On the contrary, we apply exactly the same principle ("no additional risk of harm") that we apply to other research subjects. In this instance, however, because they are destined (as a result of someone's choice) to die soon anyway, we can—without further diminishing their life prospects or imposing upon them additional risk of harm—use them as research subjects in ways that we would never use fetuses or infants who were not destined to die. "Bombs away," as a student of mine once put it.

A second example may be yet more troubling. Perhaps the most well-known instance of research gone horribly awry in this country is the Tuskegee syphilis experiment. For approximately forty years officials of the U.S. Public Health Service used impoverished, uneducated black men in Macon County, Alabama, as subjects in a project designed to study the effects of untreated syphilis. The subjects were left untreated even after penicillin was known to be effective in the treatment of patients with syphilis. We miss some of the complexity of the case, however, if we forget that the poverty, illiteracy, and race of these men meant that, even if the research were not undertaken, they almost surely would not have gotten treatment. The circumstances of their lives destined them to suffer from and perhaps die of complications resulting from syphilis.

Public Health officials were not in a position to change those circumstances. Carrying out their research would neither diminish the life prospects of these men nor impose upon them any additional risk of harm. Why not, therefore, at least gain from their plight knowledge that might benefit future sufferers? In *Bad Blood*:

The Tuskegee Syphilis Experiment, James H. Jones describes such a mode of reasoning (referring in particular to the view of Dr. Taliaferro Clark, but with, it is clear, wider reference to the motives of the researchers generally): "The fate of syphilitic blacks in Macon County was sealed (at least for the immediate future) regardless of whether an experiment went forward. Increasing the store of knowledge seemed the only way to profit from the suffering there." Nothing is lost and something potentially of medical significance is gained. Why not proceed?

A third example is, if anything, more thought-provoking still. When prisoners arrived at a concentration camp such as Auschwitz, "selections" were made that determined the life prospects of those prisoners. Many were fated to die. Discussing the way in which doctors at Auschwitz were "hungry for surgical experience," Robert Jay Lifton writes: "In the absence of ethical restraint, one could arrange exactly the kind of surgical experience one sought, on exactly the appropriate kinds of 'cases' at exactly the time one wanted. If one felt Hippocratic twinges of conscience, one could usually reassure oneself that, since all of these people were condemned to death in any case, one was not really harming them."

The justification is striking. We have met it before. By virtue of decisions others had made, these victims had no life prospects. Hence, they could not really be harmed if subjected to experiments that would never have been carried out on people not destined to die. Why not, then, gain useful medical knowledge and thereby wrest some good from tragic circumstances? It is crucial (and terrifying) to remember that the doctors of whom Lifton writes were, in many cases, ordinary people—like us—who supposed themselves to be advancing the mission of medicine.

Here, then, are three examples of reasoning that is structurally similar to the reasoning often used to defend the mediating position that permits research only on "spare" embryos. I do not say that those who argue for research on spare embryos should be equated with the Tuskegee researchers, or the Nazi doctors, or even moralists who were willing to apply exactly analogous reasoning not (let us note) to five-day-old blastocysts but to well-developed fetuses and newborn but nonviable infants. (Neither, on the other hand, do I seek to relieve the conscience of anyone who may be bothered by the similarities in argument.) I simply ponder these examples as a way of wondering whether we need to slow down the train of this conversation and think again. The compromise—research on spare embryos but no others—has its appeal. But perhaps we ought to worry about it more than we do. Are there reasons to question the appeal of this approach? I think there are.

We should notice, just for starters, that the form of the argument essentially baptizes the current practice of in vitro fertilization in this country—a practice that is, we might note, almost entirely unregulated. The argument simply accepts, for example, the routine creation of spare embryos. No doubt this practice eases the burden on those who seek IVF to overcome infertility, but there is no reason why their burden should necessarily be of greater moral concern than the production of

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spare embryos destined to be discarded. It seems unlikely that our society will—very soon—decide to rein in and rethink its IVF practices, and proponents of embryo research sometimes act as if one cannot oppose it without demanding far-reaching IVF regulation. As a tactic, of course, this is intended to stifle opposition to embryo research by requiring its opponents to bear the burden of arguing for rolling back practices now widely used. But, of course, there is no reason why we should not tackle our problems one at a time. The fact that we cannot start over and immediately construct our IVF practices in a morally better and more regulated manner does not mean that we need proceed farther down the road on which we are traveling. It may be moral progress simply to stop, even if we cannot for now turn back.

Moreover, the fact that these are spare embryos remaining after infertility treatments may actually turn the argument in quite a different direction. These embryos have already been used once in the service of someone else's project. Perhaps even, we may hypothesize, they have been justly used in that project. Certainly, at least, the IVF project uses embryos in ways that are oriented toward their natural reproductive end. But, still, they have been produced and used in an attempt to satisfy the desires of others. Is not being used once enough? Why, if they are no longer needed or wanted for reproductive purposes, should we suppose that they are still available for our use, still a handy resource for other purposes entirely unrelated to their well-being or their natural end? Why does the fact that they are destined to die, by human will and choice, make them available for our continued use?

They are destined to die anyway. What follows? Not that we should feel free to use them, but, rather, that, as Hans Jonas once argued with respect to the terminally ill, we should spare them "the gratuitousness of service to an unrelated cause." Given that certain choices have been made, these spare embryos are destined to die, but our relation to their dying is not a matter for moral indifference. It is one thing for us to acquiesce in their death; it is quite another for us to embrace their death as our aim, to seize upon it as an advantageous opportunity to use them yet again for our purposes.

They are destined to die by our will and choice. What follows? Not that we should feel free to use them, but rather that, having condemned them to their fate, we should refrain from the added indignity of regarding them as handy research material. We cannot pretend that they simply are dying—as if that were a natural fact independent of our will and choice. First we decide that they must die. Then we say that, since they're destined to die anyway, we might as well gain some good from that tragedy. Looked at in this light, the argument seems inherently corrupting.

Sometimes, of course, it will be tempting to think that we should at least seize the opportunity to redeem their loss by using them to seek good for others. This is a fascinating thought, depending, as it does, on the intuition that an evil is done here and is in need of redemption. More than a quarter century ago, writing about

the ethics of fetal research, Paul Ramsey contemplated similar claims about the need to gain at least some good from the deaths of aborted fetuses. He suggested that only a religious commentary could adequately explain the need to find a salvific or redemptive purpose in research upon condemned and dying human subjects. "Collectively guilt-laden, we go on . . . to other potential harms and wrongs in order to avoid acknowledging the first. . . . We are determined to wrest by our scientific good works" some benefit from the deeds that engender guilt in us. The issue of embryo research is not precisely the same as fetal research, of course, but the insight into our ready recourse to the quasi-religious language of finding some redeeming good in what we do is illuminating.

We need to think again about the spare-embryo argument. Initially appealing as it may be, offering it seems a chance to move forward with research while still drawing a significant moral line, it begins to lose its force the longer we ponder it and the harder we press on it. The very form of the argument—"he'll die anyway; we might as well get some good from his dying"—seduces us into supposing that all moral evils must be forms of "harm." "No harm, no foul" may work well enough for officiating basketball, but it does not work well for sorting through our moral obligations. Reducing all moral evils to harm, we blind ourselves to issues of dignity and justice—as if, for example, we would not wrong a permanently unconscious person by selling tickets for others to observe him.

We need to slow down, think again, and draw back, lest we train ourselves to think in ways that diminish us as a people. Perhaps this means—though it's hard to say for sure—that the pace of medical progress must be slower than it could be. If so, that only means that here, as in so many other areas of research, we accept and honor necessary moral limits. For, as Paul Ramsey also put it, "the moral history of mankind is more important than its medical history."

APPENDIX C

[Elizabeth Fitton is assistant to the editor of National Review. This article appeared June 5 on National Review Online (www.nationalreview.com) and is reprinted with permission.]

We've Only Just Begun

Elizabeth Fitton

At the end of April, the last remains of handicapped and mentally ill children who had been used in Nazi medical experiments were buried in Vienna, Austria. The Nazis viewed them as lebensunwertes Leben, or life unworthy of life, and used them to research various diseases, usually killing them with barbiturates. Most of the parents who brought their children to places like the children's clinic Am Spiegelgrund believed they would be cared for, not murdered. (They were mainly non-Jews; Jewish children were usually sent straight to the camps.)

In 1997 Dr. Heinrich Gross, a lauded Austrian researcher, was exposed for his role in Spiegelgrund. His medical library consisted of these helpless children's body parts, and currently there is a movement in Austria to strip the now mentally incompetent, 86-year-old Gross of his license and national awards.

It's incomprehensible to think of what those defenseless children had to endure at the hands of the medical doctors who "treated" them. They were seen as little short of lab rats, whose value was measured only by what new information on genetic, congenital, and hereditary disorders the medical community could obtain from their dissected brains. Thank goodness we've dismissed such amoral notions as barbaric and cruel. Oh, wait. We haven't.

I recently attended a dinner honoring my mother for her work in the pro-life movement over the past 30 years. The money raised was allocated for the local Good Counsel home which houses, feeds, and helps educate unwed mothers. Speaking to an audience of about 70 or so—most of whom had been with her from the onset—my mother recapitulated the right-to-life movement in our little county just north of New York City, which was a powerful force behind the greater state-wide effort beginning in the early 1970s. The "fanatics," as some opponents called these people, consisted of members of the Knights of Columbus, workers for Birth-right and Good Counsel—which provide instruction, support, and safe havens to single mothers—and other activists. These were not just friends and admirers of my mother; they were her fellow foot soldiers in the pro-life struggle. They had traveled to Albany and to Washington, D.C., year after year to attend rallies, marches, and legislative sessions. They were full-time mothers and fathers who had found a few hours to stuff envelopes and trek door-to-door with petitions. Many of my own childhood memories of my mother revolve around the movement. Even while tending to her ten children, she was on the phone, at budget meetings, attending marches, participating in prayer vigils, soliciting new members. (In later years, she served jail time twice for refusing to vacate the entrance to abortion clinics.) It was a bona fide grassroots effort. Many people scoffed at them, insisting that legal abortion was the mark of a free and civilized society—a sign of progress.

Thirty years' worth of struggle was represented at that dinner. I don't know if I felt invigorated, or just discouraged, by hearing about all that they did and sacrificed—even while realizing what new and still more convoluted battles today's pro-lifers face. During the initial stages of the right-to-life movement, many people dismissed as alarmist and absurd the "slippery slope" idea that legalized abortion on demand would only lead to further disregard for other stages of human life—through procedures such as euthanasia, not to mention partial-birth abortion. And very few people, even in the pro-life movement, could have predicted the advent of embryonic-stem-cell research and cloning. The farfetched ideas once confined to science-fiction novels and movies are now 21st-century realities.

According to their proponents, embryonic-stem-cell research, human cloning, and even partial-birth abortion are all methods of saving and improving those lives already outside of the womb. Yet the hypocrisy is glaring. It is becoming more and more difficult to deny the humanity—both potential and immediate—of these embryos. Indeed, it is precisely because these supposed "incipient cells" constitute the genetic makeup of a real-life human being that they have research value. They are definitely "life"—just not as meaningful as those of us who were lucky enough to get past that first stage of development. Even Sen. Orrin Hatch, who prides himself on his pro-life record, has come out in favor of human-embryo cloning, rationalizing that an embryo not implanted in a woman's womb is unequal to one that has been implanted. You know what they say: location, location, location. So, Sens. Hatch, Ted Kennedy, and Dianne Feinstein have introduced legislation supporting human-embryonic cloning—but only if researchers promise to behave and not implant those embryos in a womb, artificial or real. And what do we do with those that inevitably will be implanted into a womb (especially in an artificial one)? Because as we've already seen, there always will be new and seemingly life-affirming reasons to proceed with implantation—as with any new, controversial procedure. We admit that it's all a form of life, but what we as a society refuse to concede is that we are in effect putting the fate of certain lives at the mercy of those who happen to be in a position of control.

This belief that life can be categorized is exactly what permitted those innocent children to be used by Dr. Gross and his henchmen. No one wants to be labeled callous, allowing a person with Parkinson's disease continue to suffer rather than do a few experiments on some cells. Yet how can we watch delicate, breakthrough fetal surgery on the Learning Channel, marvel at the latest GE sonograms providing four-dimensional images of unborn babies—and still justify abortion? How can we gasp in horror at the ex-cop who mows down a family that includes a pregnant mother—but say that had she had chosen to get rid the unborn child herself, that would have been her constitutional right?

The newest generation of pro-lifers have an arduous task ahead of them. But respect for all life—now and to come—is at stake. The attendees at my mother's dinner still have hope. They have seen progress. Abortions have decreased; and most Americans, on both sides of the issue, agree that abortion is something to

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avoid. Yet states are still flirting with legalizing assisted suicide, and even people who consider themselves anti-abortion are trying to emphasize the “greater good” of embryonic research. Today’s pro-lifers need to educate themselves, especially when it comes to the obscured success stories of adult stem cells and related issues. In the mid 20th century, many citizens were ignorant of what was really happening in those Nazi clinics; but we are certainly not.

I tried to feel hopeful leaving my mother’s dinner; but there are many signs we have not advanced all that far from the thinking of those Nazi doctors. Yet the mothers and children who live at the Good Counsel home are a living testament to the positive impact and successes of the movement. The veteran members of the pro-life cause who first galvanized the movement—starting from the bottom up—were a constant presence, a conscience that would not stop reminding people of the truth.

Some might say none of the concerns of today is comparable to those Nazi atrocities. But the Dr. Grosses of that time did not think what they were doing was atrocious; rather, they believed they were benefiting mankind with their research. The first step to that numbing of the conscience was taken when they decided what was lebensunwertes Leben. Today, we face much the same question.



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[Sidney Callahan is a columnist for Commonweal magazine where this article originally appeared (June 14, 2002). © 2002 Commonweal Foundation, reprinted with permission. For subscription information, visit their website at www.commonwealmagazine.org.]

Zygotes & Blastocysts: Human Enough to Protect?

Sidney Callahan

As debates over stem-cell research and cloning roil on, proponents of scientific research ask their opponents: “But why do you want to protect human zygotes, blastocysts, and embryos from manipulation or loss? How can you care about the inviolability of these ‘clumps’ of developing cells, ‘no bigger than the period at the end of this sentence’?”

But why is size an issue when there is so much inherent developmental capacity? Surely size in a world of quarks, quantum events, and neutrinos is relative. In the microrealm a zygote and blastocyst can appear pretty gigantic. Scientists who describe the big bang claim that at its beginning the whole universe was many times smaller than a single fertilized human cell.

Human zygotes also have a long lineage. They are the incredibly developed endpoints of millions of years of evolutionary change. The active genetic information in the microscopic initial stages of human life is as dynamically potent as a nuclear explosion. Replaying the movie of every human life brings you back to these beginning cells with their specific human characteristics. After all, it is this very capacity for potential that makes scientists want to manufacture, dissect, and destroy embryos in their research.

When George W. Bush announced his ban on new embryonic stem-cell research, he used the image of a snowflake to call attention to the valuable uniqueness of each nascent life. But this image doesn’t go far enough. Each zygote’s dynamic uniqueness makes it a natural wonder of the world, far surpassing Niagara Falls or the Grand Canyon.

As evolutionary biology has progressed in understanding the developing saga of human life, it has also honed our awareness of our common genetic heritage. We share an identity as one species. Each instance in time of embryonic human life is related to all the rest of the human family, and not just to its progenitors. The human species lives from generation to generation as an interdependent unitary whole. How misguided it is to think it acceptable to divide humankind into bits and pieces of disposable property.

So far as we know, life as complex as ours is unique in the universe. From a cosmic space/time point of view, full to bursting with millions of galaxies, the duration of the existence of any living member of the human species—embryo or Roman emperor—appears as an amazing flicker of light.

Yet I think the evolution of our vulnerable species in a mega-universe explains away another accusation made against defenders of nascent human life. Pro-research types argue that since people don’t mourn or provide funerals for the large

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numbers of spontaneously aborted fertilized zygotes, zygotes cannot be considered to have value equal to other human lives.

This argument ignores the 100 percent mortality rate of human beings, and the fact that people do not mourn the thousands of undeniably adult lives lost in distant floods, famines, or volcanic eruptions. Our race has evolved in small groups with limited cognitive and emotional capacities. We can mourn only those familiar intimates we have known. Naturally no one (outside of disappointed women in infertility clinics) mourns lost embryos. But being unmourned, unknown, or unwanted does not render human life valueless.

Fortunately, human beings have evolved the moral understanding to grant the inalienable dignity of other members of the human family who radically differ from themselves. Strong and competent adults can accept their moral obligation to protect the fragile and vulnerable—no matter how immature, impaired, demented, diseased, or dying. Dependency and the need for mutual care mark the whole human life cycle, from conception to death. Humankind should be afraid of the bitter consequences suffered from drawing exclusionary lines to determine which human lives aren't worthy of protection.

All right, I know, slippery-slope arguments are not philosophically elegant, but they do carry force in practical affairs. Limiting the imperative to experiment and destroy in a good cause has already been proved nearly impossible in arenas such as science and warfare. Creating embryos to destroy them eventually for the sake of more knowledge already seems quite acceptable. And then, inevitably, on to the next frontier?

It is disappointing that many Catholic thinkers can give a green light to experiments with human life. They are not convinced that embryos are human enough to protect, because they do not meet developmental criteria that hark back to medieval philosophical categories of thought. Some of these thinkers do not grant that in today's biology, activated genetic information is what we mean by form. By viewing embryos as individualistic entities, isolated and unembedded in evolutionary history and species identity, these thinkers would deny them equal moral status, at least until fourteen days, or implantation, or some other arbitrary milestone. Too bad. Snowflakes need no protection, but human embryos do.

APPENDIX E

[This article appeared on July 12, 2002 on the Daily Standard Online, a publication of The Weekly Standard, where Mr. Bockhorn is an associate editor. Reprinted with permission. © Copyright 2002, News Corporation, Weekly Standard, All Rights Reserved.]

“I Don’t Have a Choice”

Lee Bockhorn

Last Sunday, the New York *Times Magazine* published a remarkably chilling essay entitled “Family Planning.” Penned by an anonymous father—let’s call him Mr. X—it described his family’s efforts to convince his pregnant 15-year-old daughter, against her own better instincts, to have an abortion.

Doubtless, the *Times* published it as a shining example of how families should persuade pregnant teens that abortion is preferable to bringing an “unwanted” child into the world. But in many respects, the essay actually serves as a damning rebuttal of arguments commonly made by true believers in abortion-on-demand.

According to Mr. X, his younger daughter has been a challenge for many years. Unlike his well-behaved eldest daughter, the young one “smokes cigarettes and marijuana and doesn’t care who knows,” among other things. Mr. X hypothesizes that this behavior is a response to some sort of identity crisis—in contrast to the goody-two-shoes older daughter, the 15-year-old “feels she has to carve out her own identity by doing what she pleases.”

After learning she was pregnant, the girl said she wanted to keep the child, and promised she would be a good mother. In response to this, Mr. X and his wife “freaked, and not just because of our dashed aspirations for this girl. We were too old to want to raise another baby—and we felt sure the raising would fall to us.”

The belligerent selfishness of this statement is nothing less than breathtaking. Upon hearing that their daughter, faced with the difficult circumstance of a teenage pregnancy, nevertheless courageously desired to raise her child, Mr. and Mrs. X couldn’t bear to think about how to help her cope with the inevitable challenges ahead. Instead, they worried about what a royal pain in the ass the child would be for them. As Mr. X whines later in the essay, “We felt we had been sentenced to 18 years of hard labor.”

Faced with this, then, as Mr. X goes on to describe, the family staged an “intervention,” inviting 15 female relatives and friends to the house to exhort the girl to have an abortion. Having still failed to change her mind, Mr. and Mrs. X then took her to a counseling session at Planned Parenthood.

When they returned home, the parents asked the daughter what she was going to do. “I don’t have a choice,” she replied. She went on to have the abortion.

With those five simple words, “I don’t have a choice,” “Family Planning” effectively exposes the sham of “women’s autonomy” as an argument for unfettered abortion on demand. Mr. X sniffs at the parental consent laws of his “Bible-belt state,” presumably because they infringe upon such autonomy—the ability of any woman, even a minor, to make her own decision about bringing a child into the

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world. But in fact, his real concern is not to protect such autonomy; otherwise, why expend so much effort convincing the girl that keeping the baby will place such an undue burden on all those around her? When the woman's autonomous choice proves inconvenient for others, suddenly their reservations demand recognition. Earlier, Mr. X stated with resignation that he no longer grounded his daughter to stop her pot-smoking, because she had realized that "there was no way we could forcibly make her do anything she didn't want to do." But this doubt about his parental ability (and obligation) to alter his daughter's bad choices flew out the window when it became necessary to force her to abandon her silly desire to have her baby.

After the abortion, Mr. X tells us, "I realized later that I would have more to worry about if she had easily and immediately decided on an abortion. Ultimately, she did, but she struggled with her decision, and I hope she made the right one."

It's difficult to know where to begin parsing these two sentences. First, they merely regurgitate the argument feminist author Naomi Wolf made some years ago: namely, that abortion is acceptable, provided that women who have abortions experience some vaguely defined type of contrition, regret, remorse, what have you—in other words, that they at least acknowledge they are taking a life.

But what's more astonishing is the father's statement, regarding his daughter's "decision," that he "hope[s] she made the right one" (if something resulting from such familial browbeating can truly be called a "decision"). Whence came such sudden moral uncertainty, Mr. X? By all the criteria he has presented in the article, of *course* she made the right decision. After all, she's not sentencing her poor parents to "18 years of hard labor."

The father concludes by telling us that he still has hope for this daughter; that one day, the good little girl he once knew, who as a 4-year-old held her best friend's hand until the very end as she died of cancer, will one day return. "I know that person is in there, and someday, when the fever [of adolescence] breaks, I pray that I'll see her again." If he wasn't so morally blind, Mr. X would have realized that he *had* already seen her again. The girl who wanted to raise her baby and promised to be a good mother was a person who—apparently for the first time in many years—had recognized that some things are more important than just living for the sake of one's own pleasure or convenience; that sometimes our duties to others transcend the need to "carve out an identity" by "doing what one pleases." Too bad, both for her and the child she will now never know, that her parents haven't yet learned that lesson themselves.

APPENDIX F

[The following appeared on July 23 on the Pro-Life Infonet (www.prolifeinfo.org) and is reprinted with permission. Mr. Ervin lives in Chicago.]

There's No Such Thing as a Mercy Killing

Mike Ervin

Sometimes, in spite of my own perfectionist's resistance, I can't help but feel moments of great satisfaction about the positive changes brought about by the disability rights movement. And then along comes a newspaper story about a so-called mercy killing.

The murderer is almost always a distraught care-giving relative who couldn't take it any more. The killer's communities and defense attorneys rally around them by describing those they killed with the most deeply dehumanizing terms in the lexicon of victim-blaming. They were sufferers, they were helpless, they were hopeless, they were burdens.

Most depressing and outrageous is when the press goes along for the ride by giving this viewpoint the first bit of credence. The latest example is the story of Carol Carr, 63, who was charged with two counts of murder last month for shooting to death her two sons, Andy Bryon Scott, 41, and Michael Randy Scott, 42. Both men had Huntington's disease and were living in an Atlanta-area nursing home.

The *Chicago Tribune* published a commentary in defense of Carr's alleged actions. Lewis Whittington wrote of the "nightmarish" existence of living with a "degenerative" disease. And what a parallel living hell it is, he said, to have to be the one who lives with them, who has to bathe them and move their limbs and dispose of their bodily waste.

When he talks about people with degenerative diseases, he's talking about me. I have muscular dystrophy. I need someone every day to help me bathe and move my limbs and dispose of my bodily waste. And when he talks about family members who can't give them the help they need, he's talking about me too. My mother loves me dearly as I love her. She would do anything for me. But she's in her seventies and she just can't do everything I need.

So do I deserve a bullet in the brain?

The hell Whittington described is a hell of our own creation. I live in my own condo and a state program pays for people to assist me at home under my direction. My situation is light years away from hopeless. Hope comes in many forms. For me it comes in the form of those who come assist me. Everyone deserves these options that bring hope, whether it's pain management or technology that facilitates communication or whatever.

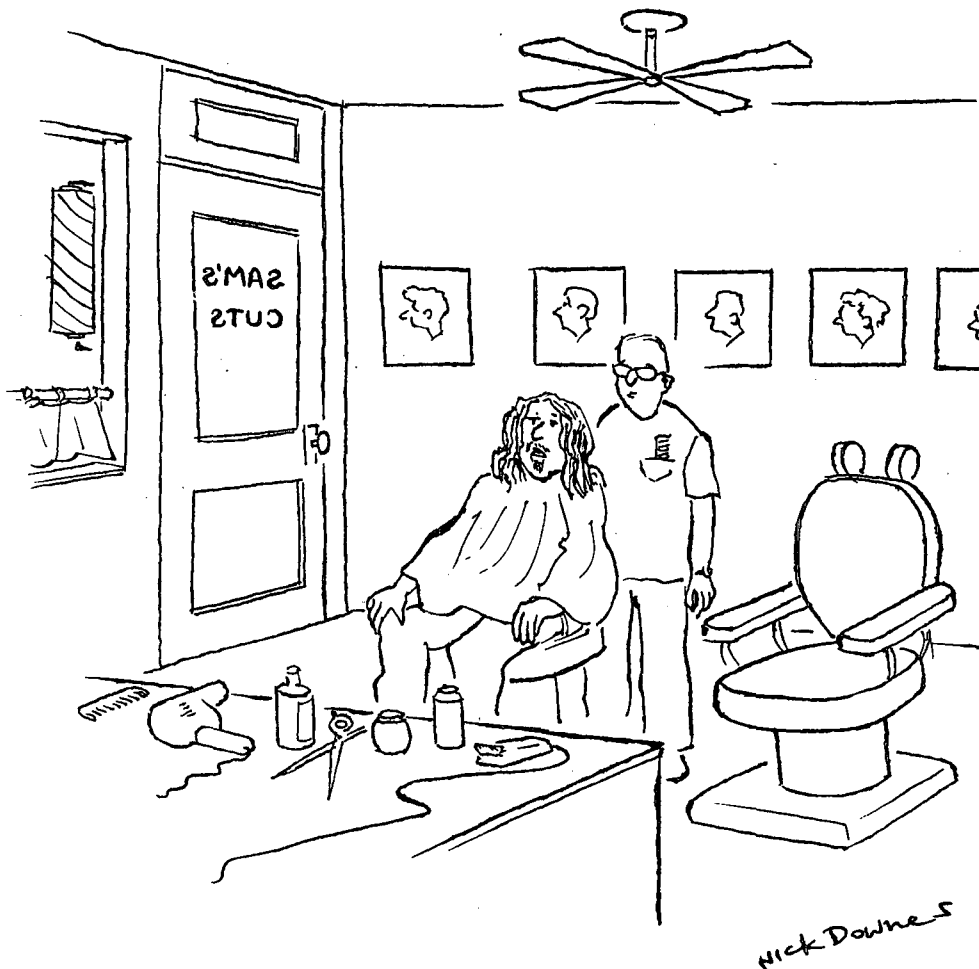
But it makes me wonder how we ever reached the level of enlightenment necessary to create such programs when we are still capable of treating people like the Scott brothers with such profound contempt. When they need help, we shrug and say it's a family responsibility. When it's too much for the family, we offer no

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alternatives but surrender to a nursing home or death. No wonder they perceive themselves as hopeless.

And then we mock their memories by dismissing their deaths with the disdainful oxymoron of mercy killing. We say killing a human being is murder but killing *them* is something less.

How demoralizing it is to be reminded just how unwelcome people with disabilities still are in our culture. We should use the death of the Scott brothers to dedicate ourselves to creating the kind of supportive society where no one is ever made to feel like a burden.



*"I'm not a kid anymore, Sam.
Pull it all back in a severe bun."*

APPENDIX G

[Dr. David van Gend is Queensland (Australia) spokesman for TRUST, a national alliance of doctors and lawyers opposing euthanasia and promoting palliative care. The following appeared in the Canberra Times on June 3, 2002 and is reprinted with permission.]

Nancy Crick's Death Not in Vain

David van Gend

Nancy Crick was not dying. She was not terminally ill, she did not have cancer, she was almost twice the body weight stated on her web site and gaining. And she did not die. She committed suicide, which avoids dying, avoids reading the final chapter of the human story for fear of what it might hold.

That fear is the key to understanding the "right to die" movement; it is the "afraid to die" movement. It is the "life has no meaning" movement.

In *Search for Meaning*, broadcaster Caroline Jones accompanies a friend through her process of dying. "The disfigurement of her illness was pitiful; it would have shocked no-one if she had asked for death," she says. "But patiently she lived through her last days, until one evening, calmly, she took her last breath.

"It was a moment of heightened significance, almost excitement, certainly sacred. The sense was of a rite of passage safely traversed."

What a pitiful contrast to Mrs. Crick's suicide on May 22. Alone even in company, since no-one can look suicide in the eye. A moment of debased insignificance, except in the minds of Euthanasia Society activists triumphing ghoulishly over their media coup.

Yet Nancy Crick has not died in vain. She has exposed her doctor, Philip Nitschke, as cynical enough to do whatever it takes to manipulate public opinion. And, more significantly, she flushed out an admission of his true philosophical agenda—death on demand—with his assertion that it didn't matter whether she had cancer or not. You don't need cancer, you don't need to be dying or even suffering pain, you only have to desire death.

Another pro-euthanasia doctor reluctantly admitted to me that even a healthy teenager who persistently asked for assisted suicide, after full medical assessment, had that right to assistance.

Now at least the public better understands the package they are buying from Nitschke if they support the alleged right to death on demand. The second good thing to come from the Crick debate is the opportunity to reflect on the laws prohibiting assisted suicide, and to see them anew as necessary and to be upheld. The principle of justice involved is that no vulnerable person is to be put under the influence of another to choose death.

The law deters involvement in another's suicide, not to make suicide a lonely affair, but because the involvement of any other person raises the possibility of malicious pressure being brought to bear to choose suicide.

For those who cannot believe in such pressure, consider a letter sent only days ago to one of my patients by her sister, to which I refer with permission. It abuses

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my patient as a “no-hoper” who “should die,” and blatantly demands all proceeds from her will.

This is a patient not endowed with great self-esteem. Any debate on assisted suicide has to take into account the grim nature of some family relationships.

When the House of Lords rejected assisted suicide and euthanasia, it concluded, “We are concerned that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to seek early death.”

Likewise the Canadian Supreme Court declared, “the responsibility of Government to protect vulnerable people from abuse outweighs any individual right to assisted suicide.” That decision was reaffirmed only last month by the highest courts in Britain and Europe. It is a just and necessary law.

While Mrs. Crick was alive, our association declined to comment on her predicament, feeling that the more highly publicised her case was, the less private freedom she had to rethink and choose supportive care instead of suicide. Now that she is dead, however, her death is the proper subject of police investigation and public comment. Nitschke has declared this to be only the start of a series of staged suicides, of a campaign of “civil disobedience” of our laws on assisted suicide. We feel that Nitschke should be prosecuted for “counselling suicide,” and made to learn that he too is under the rule of law.

If his precedent of spectator suicide is tolerated, we will have made possible a new form of oppression of the weak by the malicious strong. That must be opposed, and the current restraining law upheld.

The Medical Board will no doubt be assessing whether Nitschke has cared for his patient in a proper manner, which involves the duty to treat depression and strive to prevent suicide. At the very least the board should compel him to undergo formal training in palliative medicine, so he can be confident in easing the symptoms of advanced disease, not going with the death option through lack of medical experience.

Which raises the third and final good thing to come from the Nancy Crick debate.

It gives an opportunity for those trained in palliative medicine to remind people of the advances in the care of the dying, and encourage them away from suicide. An opportunity also to correct misconceptions like those in Crispin Hull’s article (CT, May 25) in which he states, “Hitherto, euthanasia was usually a case of a doctor quite legally administering enough morphine to deal with pain that as an ‘unintended side effect’ killed the patient.”

The widespread superstitious notion that morphine kills patients must be corrected. Properly used, morphine exactly balances pain, with negligible residue of drowsiness and no capacity to shorten life. It is thought indeed to prolong life by reducing physical stress and oxygen requirements.

Nancy Crick should still be alive. And Philip Nitschke should be prosecuted. Bizarre suicide scenes like theirs make bad law, and the law against assisting suicide must not move even one step towards exposing vulnerable old people to malicious involvement by others.

APPENDIX H

[David Davenport, a research fellow at the Hoover Institution, was president of Pepperdine University from 1985-2000. The following commentary appeared on August 15, 2002 and is reprinted with permission. © Scripps Howard News Service.]

When Pro-choice Is No-choice

David Davenport

Like most Americans, I am weary of the politics of abortion. But the California legislature will not leave it alone. If, as in other areas, California is on the leading edge of legislation that may sweep the country, we cannot ignore Assembly Bill 2194, mandating that California medical schools provide students with training in abortion. It has passed the Assembly, is on its way through the Senate, and should be on the governor's desk for signature soon.

It has been a banner summer for the California Assembly. Well into the new fiscal year, the Legislature is still unable to enact a state budget, even though the controller is docking the legislators' pay until they do. In the meantime, the Assembly managed to pass important legislation such as the bill regulating the weight of children's backpacks, and now is busy with this intrusion into the medical school curriculum that, in turn, will exacerbate the culture wars over abortion. Those who argue that we would be better off if state legislatures did not meet full-time would find ample evidence for their cause in Sacramento this summer.

The genesis of the bill is a concern that there may be a shortage of doctors to provide abortions. As some have noted, no one in California is really aware of a problem yet, with some 300,000 abortions per year performed in recent years. In most occupations, a potential labor shortage might be addressed with education or incentives for new people to enter the field. But no, those carrying the "agenda" here seek to legislate that the next generation of obstetricians and gynecologists have training in abortions. Those who wish to opt out for religious or ethical reasons must file a letter setting forth their views.

Is there no limit to regulation? Whether one is for or against abortion, surely even pro-choice advocates could respect the right of medical schools and their students to make their own "choice" about curriculum and coursework. And what about the doctor's right of conscience, his or her own choice about abortion? Isn't it possible that students who choose to care for expectant mothers and deliver their babies as a career might not choose to abort babies, or even take a course to learn those techniques? Should we not honor that "choice" also, whether or not it is based on well-formed religious or ethical grounds?

But there is an even larger issue here, the politics of education itself. We may have significant problems in K-12 education, but American higher education is widely acknowledged as the best in the world. People vote with their feet, coming by the thousands from nations all over the world to attend our universities. It is widely acknowledged that one of the great strengths of American higher education is its diversity, its pluralism. With some 3,500 colleges and universities, students can

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choose from dozens of institutional types, from research to religious, from broad to specialized.

In recent years, however, systems of accreditation, originally designed to insure academic quality, have become political battlegrounds. A few years ago, there was an effort to impose diversity requirements through accrediting associations. Only when a few college presidents, and the U.S. Department of Education, took the matter head-on did accrediting agencies acknowledge that diversity policies were really choices for individual schools, not matters to be imposed by accrediting agencies. Having all institutions follow the same approach to diversity promotes uniformity, not diversity.

In this case, the California legislature is carrying out its pro-abortion policy by mandating that all California medical schools follow the guidelines of a particular accrediting agency, The Accreditation Council for Graduate Medical Education. The question of what curriculum to follow, and which accreditations to seek, has always been the province of individual colleges and universities, not government. Do we really want to trust the politicians who have messed with the K-12 curriculum every few years to decide what courses future doctors should take? I'll take the judgment of medical deans.

Those who would use academic accreditation, and now legislation, to inject their politics into the university curriculum are starting American higher education down a dangerous and slippery slope. When Bob Dole was in the U.S. Senate, he was sometimes referred to as "Senator Gridlock" because of his opposition to various bills. When asked about it, he responded that there were a lot of bad ideas in Washington and that someone had better stop them. There are some bad ideas in Sacramento this summer and someone needs to stop them.



*"I don't care what planet he's from,
ma'am, he's gotta be in a car seat."*

APPENDIX I

[J. Bottum is Books & Arts Editor of The Weekly Standard where the following appeared (Aug. 5, 2002). © Copyright 2002. News Corporation, Weekly Standard, All Rights Reserved.]

U.N. Stands for Unconscionable

J. Bottum

When Colin Powell announced last Tuesday the administration's decision to shift to other organizations \$34 million earmarked for the United Nations Fund for Population Activities, the reaction was apoplectic. "Bush Denies Women Health Care, Human Rights," read one editorial headline. "The World's Women Left in the Lurch," read another—and on and on: "Abortion Foes Win Counterproductively," "'W' stands for Wrongheaded," "Life-Saving U.N. Effort a Victim of White House Politics." Never mind that the funding was curtailed because the UNFPA supported China's gruesome policy of forced abortions.

Meanwhile, Rep. Carolyn Maloney of New York denounced the Republicans' "mindless zeal to take care of their right-wing base." Sen. Patrick Leahy railed at the decision as "an embarrassment and a travesty." And happy with the opportunity to act as moral tutor to the backward United States, the European Union voted to replace the missing money (though carefully limiting its use to 22 former European colonies, not China), citing what the E.U. Development and Humanitarian Aid commissioner, Paul Nielson, called the "decency gap" created by the Americans.

You'd think from all of this that President Bush had declared war on half the globe. Indeed, UNFPA's executive director, Thoraya Obaid, insisted that he had, and that "women and children will die because of this decision." The Chinese Foreign Ministry, responding to the State Department's description of forced sterilizations and abortions in China, issued a diatribe against the United States. Chinese citizens' participation in Beijing's policy of one child per family is entirely voluntary, the Chinese ambassador to the United States insisted—and, anyway, the UNFPA is working in merely 32 counties in China, where the United Nations fund hopes to show that voluntary population controls work better than involuntary ones.

If this sounds like something of a contradiction—there's nothing coercive in China, except in those counties where UNFPA doesn't work—that's because it is. In the midst of the firestorm of criticism, almost no commentator noticed this wasn't merely politics for the Bush administration, some Machiavellian payoff to the president's pro-life supporters by Karl Rove, but a matter of principle. Powell is on record as being generally sympathetic to UNFPA, but his letter to Congress takes seriously the moral problem of American support for an agency implicated in China's coercive population policy—and the legal problem adhering to the 1985 Kemp-Kasten law that prohibits funding of any organization that participates in coercive abortions and the 2000 Tiahrt amendment

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that prohibits American funds' being passed on to international organizations that support coercive contraception programs. Though you would never know it from the hysterical criticisms of self-proclaimed "pro-choicers," what Powell is upholding is the idea of choice.

"If there is a single principle that unifies Americans with conflicting views on the subject, it is the conviction that no woman should be forced to have an abortion," Powell insisted. "Regardless of the modest size of UNFPA's budget in China or any benefits its programs provide, UNFPA's support of, and involvement in, China's population-planning activities allows the Chinese government to implement more effectively its program of coercive abortion."

The UNFPA, it also bears noting, is not an admirable bureaucracy that just slipped up in China. Amidst all the hyperventilating about the supposed indecency of the United States, very little attention was paid to the damning report issued last week by the Peruvian government about UNFPA's collaboration in the ruthless—and racially motivated—sterilization of 300,000 rural and Indian women in Peru during the 1990s. Begun by President Alberto Fujimori with special legislation when he assumed dictatorial powers, the program officially registered UNFPA as its "Technical Secretary" for organizing what it called "ligation festivals."

While other international organizations grew increasingly queasy with the coercive and racial aspects of the project (even the Clinton-era U.S. Agency for International Development withdrew early in 1998), the U.N. fund "increased their support and even participation in the task . . . in the period 1995-2000." UNFPA, the Peruvian inquiry found, "brought not only special financing but also demographic goals, for the focalized reduction of the Peruvian population and the fecundity of Peruvian women."

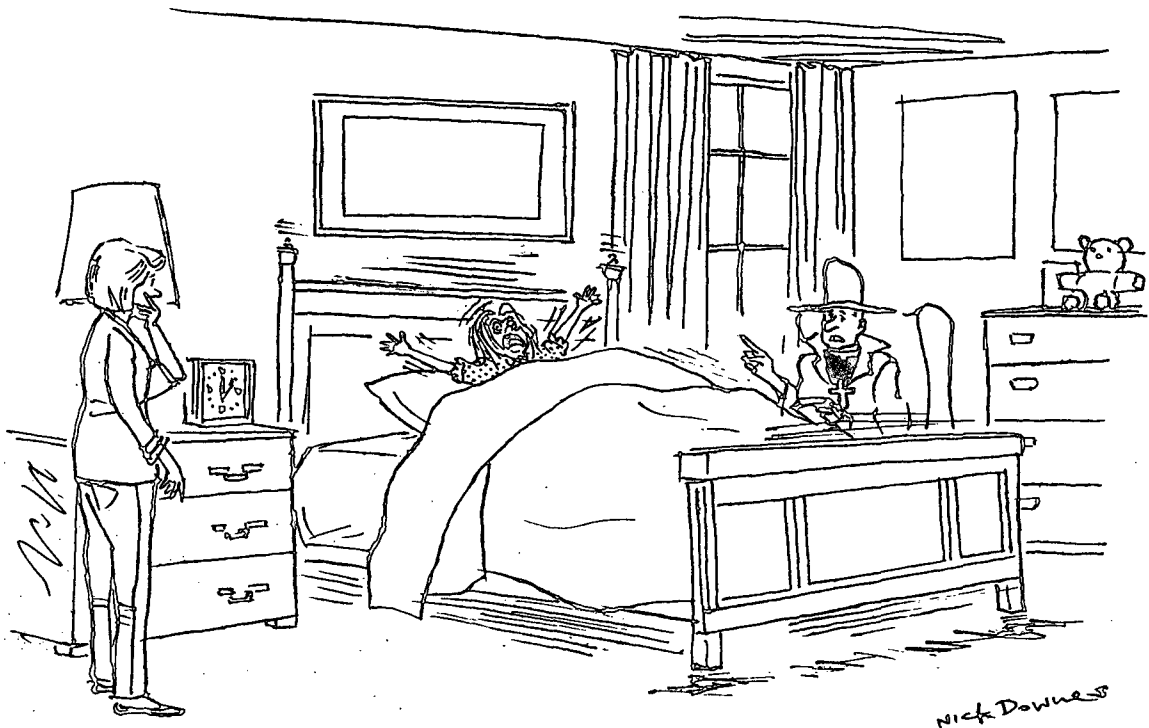
Indeed, the UNFPA's record through the years shows an institutionalized bias in favor of brute force measures. Though official UNFPA policy prohibits the promotion of abortion, over 17 percent of the fund's annual spending is passed through to non-governmental organizations that have no such restriction. Such organizations, the former director of UNFPA, Nafis Sadik, has explained admiringly, "are willing to take risks that governments certainly won't, even U.N. organizations won't, but [national governments and the U.N.] can finance." As all parties to this debate well understand, the UNFPA is part of an interlocking directorate of national and international organizations devoted to abortion, contraception, and sterilization.

Thus, after leaving UNFPA, Sadik joined the board of directors of the Center for Reproductive Law and Policy, an organization wholly dedicated to eliminating restrictions on abortion. The official U.S. Committee for UNFPA uses as its spokeswoman Robin Chandler Duke, former president of the National Abortion and Reproductive Rights Action League. When UNFPA launched the "United Nations Population Award" in 1983, it chose as one of its first recipients Qian Xinzong, the minister of the Chinese State Family Planning Commission.

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(Later, at the end of her term as head of UNFPA, Sadik was awarded the prize herself.)

Much of the American apparatus of international agencies, non-governmental organizations, women's advocacy groups, and population-control organizations is just as deeply interconnected—and just as deeply implicated in forced abortions, coercive sterilizations, and single-minded pursuit of fewer births. All that happened last week is that the Bush administration stopped pretending to believe them when they say they aren't.



"Have you got any Ritalin in the house?"

APPENDIX J

[Wesley J. Smith is an attorney for the International Task Force on Euthanasia and Assisted Suicide and a senior fellow at the Discovery Institute. He is the coauthor of Power Over Pain: How To Get The Pain Control You Need. The following appeared on National Review Online, August 19, 2002 and is reprinted with permission.]

Doctors of Death

Wesley J. Smith

When liberals ask me why they should oppose physician-assisted suicide (PAS), I always reply, "I can summarize a big reason in just three letters: HMO."

That always raises an eyebrow. Liberals hate HMOs.

Then I ask, "Do you know how much it costs for the drugs used in an assisted suicide?" They usually shake their heads, no. Answering my own question, I say, "About forty bucks," adding, "Since HMOs make money by cutting costs, and it could cost \$40,000 (or more) to provide suicidal patients with proper care so that they don't want assisted suicide, the economic force of gravity is obvious." More often than not, my liberal interlocutor will say, "Gee, I never thought about that before," and agree that the HMO factor is a very serious problem confronting the assisted-suicide movement.

Most people haven't yet made the money connection between assisted suicide and the increasing strains on health-care budgets. That may be because reporters, who are usually eager to expose potential financial conflicts of interest in other public-policy issues, tend to be blind to the economic stakes involved in the assisted-suicide controversy. They prefer to see it as a matter of "choice," or of "compassion," or of modernism-versus-religion. Yet, the realization that assisted suicide will, in the end, be largely about money, is becoming increasingly difficult to ignore.

Take Oregon, where assisted suicide is legal. While the assisted-suicide law does not compel any doctor or HMO to participate in the self-destruction of patients, only Catholic HMOs have said no. Indeed, Kaiser/Permanente Northwest's doctors are known to have written lethal prescriptions under the Oregon law.

But now, Kaiser isn't merely permitting doctors to assist in patient suicides, it is *actively soliciting* its doctors to participate in the deadly practice. As revealed by the anti-assisted-suicide medical group Physicians for Compassionate Care, a Kaiser executive recently e-mailed a memo to more than 800 Kaiser doctors soliciting PAS-doctor volunteers.

The memo reveals that to the apparent chagrin of Kaiser, to their credit, few plan doctors are willing to participate in the killing of their own patients. Hence, the executive urges any Kaiser doctor willing to "act as Attending Physician under the [assisted suicide] law for YOUR patients" and doctors willing to act as "Attending Physician under the law for members who ARE NOT your patients" to contact "Marcia L. Liberson or Robert H. Richardson, MD, KPNW Ethics Services." (Emphasis in the memo.) Since "attending physicians" write the lethal

prescriptions under the Oregon law, Kaiser is apparently willing to permit its doctors to write lethal prescriptions for patients they have not treated.

For opponents of assisted suicide who are closely following events in Oregon, Robert Richardson is already notorious as the HMO administrator who green-lighted the assisted suicide of Kate Cheney. Cheney, as reported by the *Oregonian*, was a terminal cancer patient who was probably suffering from dementia when she asked for a lethal prescription, raising serious and significant questions about her mental competence. Rather than prescribe lethal drugs, her doctor referred her to a psychiatrist who reported that "she does not seem to be explicitly pushing for this." He also determined that she did not have the "very high capacity required to weigh options about assisted suicide." Accordingly, the psychiatrist nixed the lethal prescription.

Advocates of legalized assisted suicide might, at this point, smile happily and say that this is the way the law is supposed to operate: a vulnerable and perhaps incompetent woman's life had been protected. But proving that "protective guidelines" don't really protect, that wasn't the end of Cheney's story. Her daughter insisted that Kaiser permit another psychiatric opinion. Kaiser agreed to the request.

This time, the consultation was a clinical psychologist rather than an M.D. psychiatrist. Like the first report, the psychologist found that Cheney had significant memory problems. For example, she could not recall when she had been diagnosed with terminal cancer. The psychologist also worried that Cheney's decision to die "may be influenced by her family's wishes." Still, despite these reservations, the psychologist determined that Cheney was competent to commit suicide.

The final decision to approve the assisted suicide was made by Richardson. Despite two mental-health professionals' significant concerns about Cheney's mental state and the possibility that familial pressure was involved in her decision, after he interviewed Cheney, Richardson approved the writing of a lethal prescription.

It is worth noting that Cheney did not take the poison pills right away. Her assisted suicide took place *only* after she was sent to a nursing home for a week. Tellingly, she took the pills on the very day of her return home. No doctor was present. Nor was her mental status assessed at that time. That is because under the Oregon law, once the prescription is written, death doctors need have no more to do with the suicidal patient.

When the Cheney case became public, Richardson angrily claimed that his decision had nothing to do with money. And, to be fair, there is no doubt that if the relatively few people reported as committing assisted suicide so far in Oregon is correct, Kaiser and other participating HMOs have not yet saved a great deal of money by agreeing to facilitate the assisted suicides of their terminally ill members. But if the reluctance of good doctors such as those currently refusing to participate in patient self-killing at Kaiser is ever overcome, the financial facts could change. Indeed, if assisted suicide ever became nationalized and a routine "medical treatment," significant money could be saved—and hence made—by the

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HMO industry from the hastened deaths of their patients.

This is the view of none other than assisted-suicide guru, Derek Humphry, co-founder of the Hemlock Society and a heavy lifter in support of the Oregon law. Humphry now claims that money is the “unspoken argument” in favor of legalizing assisted suicide. Specifically, in his most recent book *Freedom to Die*, co-authored with Mary Clement, the authors write that “the hastened demise of people with only a short time to live would free resources for others,” an amount they predict could run into the “hundreds of billions of dollars.” Moreover, the authors claim that “economic necessity” is the ultimate force driving the assisted-suicide movement, to the point that it “is the main answer to the question [about legalizing PAS], ‘Why Now?’”

Logic is certainly on their side. With the advent of managed care, profits in health care increasingly come from cutting costs. With assisted suicides costing such little money, what “treatment” could be more cost effective than assisted suicide? And since it is a well-known human failing that our values often follow our pocketbooks, ignoring the significant financial stakes involved in the assisted-suicide debate is to overlook a crucial part of the story.



“But I’m rambling. How was your day?”

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