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**HUMAN LIFE
REVIEW**



NAT HENTOFF
INSISTING ON LIFE

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Introduction

By

Wesley J. Smith

Nat Hentoff is a superb writer and first class public intellectual. Still, he does tend to drive people crazy. One day, they will read a Hentoff column and want to nominate him for a Pulitzer Prize for his insightful, pithy, and morally correct commentary. But come the next column, these same Hentoff partisans may pull their hair out with rage, wondering how such an obviously wrongheaded man became one of America's most venerable and respected social commentators.

The answer to this seeming paradox is as simple as it is profound: Nat Hentoff is a man of consistent, steadfast principle, a moral purist in an age of hand-wringing accommodationists. This unyielding consistency has made him an iconoclast's iconoclast. Indeed, Hentoff has described himself as "a Jewish, atheist, civil libertarian, left-wing pro-lifer." Talk about cutting against almost every societal grain: No wonder he both thrills—and upsets—so many people!

Hentoff's style is as individualistic as are his principles. In an age of shouters, he is quiet. In an era of facile talking heads, he remains profound. Where others agitate and self-aggrandize, he relies on steadfast cogent argument to persuade. Where contemporary pundits often tailor their views to cater to the powerful or popular, Hentoff courageously remains a challenger of orthodoxies.

His ability to both enrapture and enrage can be seen in these excerpts from his 1992 essay, "Pro-Choice Bigots," which is reproduced in this volume. First, he takes a swipe at the Right as he describes a harrowing experience while speaking to a pro-life convention made up of mostly religious political conservatives:

I told them that as pro-lifers, they ought to oppose capital punishment and the life-diminishing poverty associated with the policies of their Republican president. Ronald Reagan, I emphasized, had just cut the budget for the WIC program (federally funded Special Supplemental Food Program for Women, Infants, and Children). He and those who support him, I said, give credence to Massachusetts Representative Barney Frank's line: "Those who oppose abortion are pro-life only up to the moment of birth."

From the back of the crowd, and then moving forward, there were growls, shouts, and table-thumping. Suddenly, a number of people began rushing toward the platform. I said to the man sitting next to me, a leader of the flock, that I had not quite decided that this cause was worth dying for.

Yet, in the same essay, Hentoff obliterates the smug assumption of liberal secularists who breezily dismiss pro life beliefs as mere expressions of superstitious religion, writing:

Being without theology isn't the slightest hindrance to being pro-life. As any obstetrics manual—*Williams Obstetrics*, for example—points out, there are two patients involved [in pre natal care], and the one not yet born “should be given the same meticulous care by the physician that we long have given the pregnant woman.” Nor, biologically, does it make any sense to draw life-or-death lines at viability. Once implantation takes place, this being has all the genetic information within that makes each human being unique. And he or she embodies continually developing human life from that point on. It misses a crucial point to say that the extermination can take place because the brain has not yet functioned or because the thing is not yet a “person.” Whether the life is cut off in the fourth week or the fourteenth, the victim is one of our species, and has been from the start.

The author then ties his pro life theses together by drawing upon the proud tradition of American liberalism's defense of the defenseless (quoting peace activist Mary Meehan): “The traditional mark of the left has been its protection of the underdog, the weak, and the poor. . . . The unborn child is the most helpless form of humanity, even more in need of protection than the poor tenant farmer or the mental patient.” And he writes this strongly argued rational argument, not for a Catholic journal or a conservative weekly, but rather in the liberal public affairs magazine, the *New Republic*!

Hentoff's advocacy cuts a wide swath across what are often called “the life issues.” Indeed, his unyielding stand over many years against infanticide, euthanasia, and the ongoing bioethical construction of a “duty to die”—a work still in progress—has made him a moral beacon for those who believe that universal human liberty depends on society's embrace of the intrinsic equality of all human life. And for decades he has connected the dots for his vast audience, expertly charting the consequences of our steady, but not always slow, slide down the slippery slope toward a veritable culture of death.

The book you are about to read contains many of his most notable “pro life” essays. It is not for those who prefer to avoid harsh truths. The writing is excellent but the reading is difficult. But they are a clarion warning and an essential foundation to understanding how we, over many years, have been brought to the place that Terri Schiavo could be dehydrated to death to the applause of most Americans, where some state laws authorize doctors to refuse *wanted* life-sustaining treatment because *they* don't believe the quality of the patient's life is worth living (Futile Care Theory), and where some bioethicists are now proposing that mental health professionals be permitted to facilitate the suicides of patients whose self-destruction they deem to be “rational.” Indeed, Hentoff is very much a modern-day Cassandra—he is prophetic, he is usually not believed, and what he warns against inevitably comes true.

Reading Hentoff in full battle cry is not for the squeamish. The reader can

feel his righteous rage as he:

- Derides a Maryland law permitting abortion of disabled fetuses at “any-time” during the woman’s pregnancy as evidence that “Eugenics is becoming as American as ballpark hotdogs.”

- Rails in a series of articles written in 1983 and 1984 against the court-permitted starvation death of “Baby Doe,” an infant with Down’s syndrome who was denied routine surgery and basic sustenance. Pointing to where the logic of such heartless acts lead, he writes “If we are to have a brave new world of perfect babies—with parents having a second chance at aborting infants who are born defective—then do we really want the landscape cluttered with badly handicapped adults who cost more than they produce? And who are aesthetically displeasing besides?”

- Demonstrates how the drive among bioethicists to ration health care is indeed leading to a duty to die among the old. “This is naked utilitarianism—the greatest good for the greatest number. And individuals who are in the way—in this case, the elderly poor—have to be gotten out of the way. Not murdered, heaven forbid. Just made comfortable until they die with all deliberate speed.”

- Decries unethical human experiments conducted in the early 1980s on babies with spina bifida in which doctors decided not to treat some infants—in part based on the family’s economic circumstances—a cruel act that Hentoff rightly condemned as a “death row for infants.”

- Repeatedly castigates the American Civil Liberties Union—to which Hentoff once belonged—as having succumbed to “zealous majoritarianism” for repeatedly litigating in favor of ending the lives of the most vulnerable in society. Hentoff, his pen dripping disdain as his ink, writes that the once respectable civil libertarian organization has, with complicit judges “engaged in a minuet of death.”

But enough of this: Describing Hentoff’s writing is a meager appetizer. The time has come for the full-flavored main course. As you will discover—if you don’t already know—Hentoff is a social critic of profound intelligence and bounteous talent who believes passionately and radically (in the best sense of the term) in the equal moral worth of every human. But more importantly, Nat’s writing reveals the substance of the man behind the writer, where we find an indomitable spirit that springs from a kind and loving heart, and, if he will forgive the metaphysical allusion, a beautiful and compassionate soul.

Wesley J. Smith
Castro Valley, California
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A Heretic in the ACLU

The American Civil Liberties Union is resolutely against capital punishment. It is also resolutely pro-choice in another matter concerning the death penalty. Is there a contradiction? Not according to the publications and legal briefs of the national ACLU and its state affiliates. For the ACLU, the right to an abortion is as firmly guaranteed by the Constitution as the right to freedom of speech.

But there are signs of heresy within the ACLU concerning *Roe v. Wade*. The conscientious objectors are still very few in number, but they are beginning to be heard. This spring, for instance, Barry Nakell spoke on “The Right to Life” before the annual meeting in Chapel Hill of the North Carolina Civil Liberties Union. Nakell, a board member of that affiliate, is a professor of law at the University of North Carolina.

He felt impelled to speak up publicly against the ACLU position because, Nakell told me, “I was feeling more and more uncomfortable in not being on the record with my friends concerning my belief that the basic civil liberty, essential to all others and presumed by each of them, is respect for the dignity of life.”

Nakell reminded the annual meeting that the principle of the dignity of life is the basis “for the paramount issue on the North Carolina Civil Liberties Union agenda since our founding: our unstinting opposition to the death penalty.” And he pointed out that the NCCLU general counsel, N. B. Smith, had published an article last year in the *Boston College Law Review* in which Smith emphasized that “life itself is plainly a basic and essential right, and the [Supreme] Court would have difficulty in plausibly declaring life to be less than fundamental.”

The heretic also prodded his audience to reconsider its attitude toward *Roe v. Wade* by reminding them that in 1975, West Germany’s highest court had interpreted the “right to life” guaranteed by the Basic Law of the Bonn Constitution as giving constitutional protection to unborn children. That “right to life” was in reaction to the Nazi regime’s pervasive destruction of “life unworthy to live.”

Yet, Nakell said in his talk, “I have reviewed the ACLU policy guide in a search for a strong statement of the principle of respect for the dignity of life, and have not found any. This is an oversight that we need to correct.”

As for abortion, the law professor made the reasonable point (in some circles) that reasonable people can “responsibly disagree about when life begins.” Some say it begins at birth. Others, Nakell among them, believe life starts at conception.

With regard to the ACLU’s position, Nakell emphasizes that in all other matters, the ACLU “stands for expansive interpretation of constitutional

liberties.” But not in terms of the rights of the fetus. Yet one would think, he said, that “if there is any doubt as to whether a fetus is a human life,” the ACLU, by tradition and principle, would be the advocate of the most powerless of all and urge constitutional protection for this developing life.

More tellingly—before an audience that has been as steadfast as Justice William Brennan in denouncing the state as executioner—Nakell observed that the ACLU, in supporting *Roe v. Wade*, thereby agrees that the Constitution protects the right to *take* life.

“The situation is a little backward here,” he noted. “In the classical posture, the Constitution would be interpreted to protect the right to life, and pro-abortion advocates would be pressing to relax that constitutional guarantee.” The Supreme Court turned it all around, however, and the ACLU agrees with the Court that some lives are less worth protecting than others.

Nakell has not been put in Coventry by his fellow North Carolina civil libertarians. He expects the dialogue will continue, and when he went to the ACLU biennial meeting in Boulder, Colo., in June, Nakell had a sense that some other ACLU members around the country were also ready for dialogue. At one meeting, when a delegate said firmly that “a woman has the constitutional right to a dead fetus,” most of those in attendance cringed. Nakell felt that was encouraging.

And one ACLU member in California has said, in a letter to me, that “no one can say with authority when life begins, but since we know that identity begins at conception, we’re obliged to give the benefit of the doubt.”

Barry Nakell tells of a bumper sticker he saw recently: “Equal Rights for Unborn Women.”

Death Row for Infants

Wayne Allen, a federal district judge in Oklahoma, has made a historic ruling in sending to trial a case in which a team of physicians decided, over a five-year period, which handicapped infants were to live and which were to die. The team's criteria included the economic circumstances of the children's parents.

The trial of the physicians and administrators at the state-run Oklahoma Children's Memorial Hospital in Oklahoma City will be the first in a federal court to explore the constitutional issues that arise when decisions on medical treatment are based on a child's degree of mental or physical handicap together with his social and economic status.

Among the plaintiffs are the parents of one of the infants who died for lack of sufficient treatment; the Spina Bifida Association of America; and the Association of Persons with Severe Handicaps. Representing them are the American Civil Liberties Union and the National Legal Center for the Medically Dependent and Disabled.

The medical team involved in this five-year life-or-death study was not in the least furtive. In fact, the case has become known in medical circles because the team, for the edification of peers around the country, published in the October 1983 issue of *Pediatrics* an article on what it had been doing.

The team focused on infants born with spina bifida—an imperfect closure of part of the spinal column. Each child was evaluated by the team. Some were recommended for “active vigorous treatment,” including an operation to close the spinal lesion as well as the implantation of a shunt to drain spinal fluid from the brain.

The parents of the other infants were told they were not obligated to have their children vigorously treated. Instead, they could choose “supportive care” only. That meant no surgery and no antibiotics to treat or prevent infection.

The criteria by which the medical team decided who was to survive included a formula intended to predict the quality of life of the handicapped child if he were allowed to grow up. One of the factors was the infant's physical and intellectual endowment. Another was society's likely contribution to the costs of raising the child. A third was the economic status of the infant's family.

As the leader of the team, Dr. Richard Gross, said on “MacNeil/Lehrer Newshour”: “We felt that if the struggle for the family would be a considerable one . . . the family was not under an obligation to treat this child, and we left them that option.”

Some of the families whose children died claim that they were never told of this quality-of-life and quality-of-the-family formula. They insist the doctors said only that they were giving a medical judgment.

John Smith—whose son, Stonewall, did not qualify for vigorous treatment and died two months after birth—was sick and living on welfare when his boy was born. On hearing afterward about the selection process, Smith told Kathleen Kerr of *Newsday*: “Whether I made \$10 a month or \$10,000 shouldn’t enter into it. If it were their own, personal child, would it get the same care [as my son got]? If they can tell me yes, I’ll be happy with what they did to my son.”

Out of the 69 spina bifida infants in the Oklahoma study, 24 received only “supportive treatment.” All these children died. Of those selected for full treatment, all but one lived, and he was killed in a car crash.

An expert in spina bifida, Dr. John M. Freeman of the Birth Defects Treatment Center at Johns Hopkins Hospital, wrote to *Pediatrics* that the study surely did prove how to get infants to die quickly. (The Oklahoma team had said in its report that “the ‘untreated survivor’ has not been a significant problem in our experience.”)

Dr. Freeman added that the 24 who died “might also have done well and might have . . . walked with assistive devices, gone to regular school, been of normal intelligence and achieved bowel and bladder control.”

One of the constitutional questions at the trial will be whether those 24 infants were accorded “equal protection of the law.”

Ending life because its “quality” doesn’t meet someone’s criteria is hardly confined to the nursery. The courts, led by the New Jersey Supreme Court, are legalizing euthanasia for people of all ages. Some are patients who are not in intractable pain, are not near death and are in no condition to ask for death—or for life.

But like the infants in Oklahoma, they are being evaluated according to various formulas. And more and more of those who do not measure up are being denied even “supportive treatment,” for it is now “ethical” for doctors to remove feeding tubes from people whose lives are judged not worth living.

I. The Pied Piper Returns for the Old Folks

A doctor was not a doctor. A doctor was the selection. That was what the doctor was—the selection.

—An Auschwitz survivor, *The Nazi Doctors*, Robert Jay Lifton

In 1983, the *Times* ran an Op-Ed piece, “Our Elderly’s Fate,” by Northeastern University sociology professors Jack Levin and Arnold Arluke. The lead paragraph was, to say the least, compelling:

“American society may be heading toward a *de facto* ‘final solution’ to the problem of a growing elderly population. This trend raises the unthinkable prospect of the elderly one day being exterminated as a matter of law.”

Having seized the elderly by the throat, the authors backed off a little. The deliberate massing of the old to take their last showers was not quite what they saw ahead. But already, “there is strong evidence that increasing numbers of frail, disabled, and financially dependent elders, most of whom are over 78, are even now, as a result of our social policies, being isolated from society and dying prematurely.”

You don’t need to rebuild Auschwitz to send a message to the old that it is time for them to enter eternity. The signals are everywhere. “Self-help manuals,” wrote Levin and Arluke, “are showing the elderly how to commit suicide. Studies show that emergency room personnel tend to spend less time and effort to resuscitate elderly heart attack victims than their younger counterparts.

“There is also a growing tendency in medical circles to *emphasize quality over quantity of life*. ‘Death with dignity’ may in some cases be a euphemism for extermination.” (Emphasis added.)

The two professors were also astute enough to look at the auguries in the popular culture. *Logan’s Run*, a science fiction movie, starred Michael York as a man in the future who, at 30, had reached the age at which he must be executed by the state. The book *Triage* “conjectures that the Government would solve the problems of old age by burning all nursing homes and their inhabitants.”

Not in America. It can’t happen here. Not that way. But five years ago, there was no way Jack Levin and Arnold Arluke could imagine that a distinguished, widely respected bioethicist would come forth with what his admirers call a “humane” way, a “morally courageous” way, of solving the problems of old age.

The method: persuading the elderly that they can be socially responsible by

having the government take away from them certain forms of costly, life-extending medical care.

After all, the kind of medical care he has in mind—heart bypass operations, for instance—would only make them live longer, vainly dreaming of immortality. But the Pied Piper would show old folks how to leave us with grace by being content with a “natural life span.”

The Pied Piper, in his autumnal colors, has brought the news of his gentle proposal in magazines, on television, and in a widely praised book.

By having their medical care rationed, he says, the aged will learn to savor the meaning and significance of their final years, for they will *know* they are final. And since the rest of society will no longer be spending so much on the health care of the old, the money saved can be used for the vast numbers of the population who are not old but need more care than they can afford—single or widowed women, members of minority groups.

This benefactor of the elderly is Daniel Callahan, director of the Hastings Center—a pacesetter in medical ethics—in Briarcliff Manor, New York. His book is *Setting Limits* (Simon and Schuster), and it has been respectfully received in just about every important periodical in the nation. He has been asked to speak about his solution to all kinds of groups. Some disagree with him, but they all take him seriously.

I confess that when I first heard distant word of this notion of the elderly going gently into that good Callahan night, I thought he was putting us on. (I should have realized that the Hastings Center—where he and other bioethicists labor to tell us how to fit our lives and deaths into their designs—long ago found humor far too spontaneous and certainly too personal for its religion of utilitarianism.)

Still, I expect that the sardonic Dean of Dublin’s Saint Patrick’s Cathedral, Jonathan Swift, would appreciate Daniel Callahan’s *Setting Limits*—though not in the way he would be supposed to. Swift, you will recall, at a time of terrible poverty and hunger in Ireland, wrote *A Modest Proposal*. Rather than having the children of poor continue to be such a burden to their parents and their nation, why not persuade the poor to raise their children to be slaughtered at the right, succulent time and sold to the rich as delicacies for dining?

What could be more humane? The children would be spared a life of poverty, their parents would be saved from starvation, and the overall economy of Ireland would be in better shape.

So, I thought, Callahan, wanting to dramatize the parlous and poignant state of America’s elderly, as described by Jack Levin and Arnold Arluke, had created his modern version of *A Modest Proposal*.

I was wrong. He’s not jiving.

So let us look at the Callahan way of ordering the future of America's elderly.

First, Callahan sees "a natural life span" as being ready to say goodbye in one's late seventies or early eighties. He hasn't fixed on an exact age yet. Don't lose your birth certificate.

If people persist in living beyond the time that Callahan, if not God, has allotted them, the government will move in. Congress will require that anyone past that age must be denied Medicare payments for such procedures as certain forms of open heart surgery, certain extended stays in an intensive care unit, and who knows what else.

Moreover, as an index of how humane the spirit of *Setting Limits* is, if an elderly person is diagnosed as being in a chronic vegetative state (some physicians screw up this diagnosis), the Callahan plan mandates that the feeding tube be denied or removed. (No one is certain whether someone actually in a persistent vegetative state can *feel* what's going on while being starved to death. If there is sensation, there is no more horrible way to die.)

What about the elderly who don't have to depend on Medicare? Millions of the poor and middle class have no other choice than to go to the government, but there are some old folks with money. They, of course, do not have to pay any attention to Daniel Callahan at all. Like the well-to-do from time immemorial, they will get any degree of medical care they want.

So, *Setting Limits* is class-biased in the most fundamental way. People without resources in need of certain kinds of care will die sooner than old folks who do not have to depend on the government and Daniel Callahan.

I am aware that there are more limits—in all respects—to the lives of the poor than to the lives of the comfortable. But there is something almost depraved about so brazenly discriminatory a plan coming from the director of a place that derives all its income and its considerable prestige from its reputation as a definer of ethical behavior—in the healing arts particularly.

Callahan reveals that once we start going down the slippery slope of utilitarianism, we slide by—faster and faster—a lot of old-timey ethical norms. Like the declaration of the Catholic bishops of America that medical care "is indispensable to the protection of human dignity." The bishops didn't say that dignity is only for people who can afford it. They know that if you're 84, and only Medicare can pay your bills but says it won't pay for treatment that will extend your life, then your "human dignity" is shot to hell.

What does Daniel Callahan say about this—uh—imbalance of justice? In the course of an appearance on the December 25, 1988, *MacNeil Lehrer News Hour*, Callahan said:

". . . After the age of 80 or 85, wherever we might set it [the age of limiting medical care], then I agree injustice might set in. However, it seems to me in the

nature of the case, it would not be for a very long time.”

There’s a logical man. It would indeed not be for a very long time, and all the shorter for the intervention of Mr. Callahan.

He noted on the same program that his is not an ideal proposal, “but I think the hard choice of that injustice at a later age is well worth the kinds of gains we would get in a more rounded, coherent health care system.”

Again, this is naked utilitarianism—the greatest good for the greatest number. And individuals who are in the way—in this case, the elderly poor— have to be gotten out of the way. Not murdered, heaven forbid. Just made comfortable until they die with all deliberate speed.

It must be pointed out that Daniel Callahan does not expect or intend his design for natural dying to be implemented soon. First of all, the public will have to be brought around. But that shouldn’t be too difficult in the long run. I am aware of few organized protests against the court decisions in a number of states that feeding tubes can be removed from patients—many of them elderly—who are not terminally ill and are not in intractable pain. And some of these people may not be in a persistently vegetative state. (For instance, Nancy Ellen Jobes in New Jersey.)

So, the way the Zeitgeist is going, I think public opinion could eventually be won over to Callahan’s modest proposal. But he has another reason to wait. He doesn’t want his vision of “setting limits” to go into effect until society has assured the elderly access to decent long-term home care and nursing home care as well as better coverage for drugs, eyeglasses, and the like.

Even if all that were to happen, there still would be profound ethical and constitutional problems. What kind of a society will we have if we tuck in the elderly in nursing homes and then refuse them medical treatment that could prolong their lives?

And what of the physicians who will find it abhorrent to limit the care they give solely on the basis of age? As a presumably penitent Nazi doctor said, “Either one is a doctor or one is not.”

On the other hand, if the Callahan plan is not to begin for a while, new kinds of doctors can be trained who will take a utilitarian rather than a Hippocratic oath. (“I will never forget that my dedication is to society as a whole rather than to any individual patient.”) Already, I have been told by a physician who heads a large teaching institution that a growing number of doctors are spending less time and attention on the elderly. There are similar reports from other such places.

Meanwhile, nobody I’ve heard or read on the Callahan proposal has mentioned the Fourteenth Amendment and its insistence that all of us must have “equal protection of the laws.” What Callahan aims to do is take an entire class of people—on the basis only of their age—and deny them medical care that

might prolong their lives. This is not quite *Dred Scott*; but even though the elderly are not yet at the level of close constitutional scrutiny given by the Supreme Court to blacks, other minorities, and women, the old can't be pushed into the grave just like that, can they?

Or can they? Some of the more influential luminaries in the nation—Joe Califano, George Will, and a fleet of bioethicists, among them—have heralded *Setting Limits* as the way to go.

Will you be ready?

II. 'Life Unworthy of Life'

Dr. Edmund Pellegrino, director of the Kennedy Institute of Ethics at Georgetown University, is also professor of Medicine and Medical Humanities at Georgetown University Medical Center. And he is a world-class bioethicist. He still sees patients because he does not want to forget what medicine is all about—the *individual* patient.

He will tell a patient, "In the moment of truth, the last thing protecting you is my character." At the core of his character is a resistance to what he calls "the physician as an instrument of productivity."

Health care has indeed become an industry, and there is increasing pressure—from government, from third-party insurers, from hospitals—to cut medical costs. The results, as Paul Starr, a Princeton University sociologist, puts it, are that "there has been a shift from clinical to financial control of ethical decisions."

Including, increasingly, the decision as to who shall live and who shall die.

Consider Dr. Devra Marcus, a Washington internist, who decided to work for a prepaid health plan. As she told the *New York Times* (March 20), her first two patients were diabetic, and therefore she referred them to an ophthalmologist. Dr. Marcus had to know if the diabetes had led to retinal changes which, if undetected, could lead to blindness.

The two patients were also referred by her to a podiatrist to check whether the diabetes had led to nerve damage that, in time, could make amputation necessary.

Another doctor who worked for that health plan warned Dr. Marcus, according to the *Times*, "that the cost of those specialists would come out of a special fund earmarked for her. The fewer patients she referred [to specialists], the more money she would receive from this fund at the end of the year."

After all, unless the costs of the care in this prepaid plan were kept low, how could the plan and the participating physicians maximize their income?

Dr. Marcus is now back in private practice. Like Dr. Pellegrino, she does not want to be an instrument of productivity. She prefers to think about what is best for her patients.

There has been another change in medicine as a result of concern about costs. In my view, this change has its roots in a growing coldness in the society as a whole toward life—especially life that is unproductive or defective. Are such lives worth saving, particularly if the bill is high?

As Robert Jay Lifton notes in *The Nazi Doctors* (Basic Books): “The Nazis based their justification for direct medical killing on the simple concept of ‘life unworthy of life’ (lebensunwertes *Leben*).”

We do not directly kill the unworthy, although California may be the first state to make it legal for a physician, under certain conditions, to kill a presumably hopeless patient—at the request of the patient. The proposal is likely to be on the ballot in November.

Apart from what may happen in California, however, we do believe that some lives are not worth the cost of saving. The Nazis had different criteria for designating certain categories of life as disposable, whatever their natural life span might have been. We, on the other hand, do not gas Jews, gypsies, homosexuals, and other “inferior races.” But we are becoming accustomed to thinking about denying life—extending treatment to people who cannot pull their weight in the world.

I mean, for example, certain categories of those people who do not have the money to pay for their own medical care, and therefore must depend on the state—on the taxes you and I pay—to keep them alive.

Britain is somewhat ahead of us in packing off to eternity those who are too expensive and/or are unproductive. Dr. Pellegrino tells of being in London not long ago for a medical conference where an English doctor told him he had recently refused to do a coronary bypass on a 52-year-old man. The procedure was clearly indicated, and without it, the patient would not be around much longer.

The English physician explained that the man was a coal miner, but even with the operation, he would never have a job again. Accordingly, the doctor decided that it was not fair to society to prolong this man’s life because then society would have to keep putting money into this unproductive person for who knew how many years.

But was it fair to the patient to speed him on to death? Fairness to the individual patient is beside the point. In Britain already—and we are quite close to this—health care is seen as utilitarian in purpose: the greatest good for the greatest number. Keeping some individuals alive is too expensive to be justified as being for the greatest good of the greatest number.

Sorry, your ticket has taken you as far as your fellow citizens want you to go.

In this country, a woman identified as D.C. is one of those people whose needs are too much for society to want to handle. Of course, her medical needs are too much for her to handle, too. Her story is in a publication of the Health Care Quality Alliance, a coalition of organizations ranging from the American Cancer Society to the American Society of Internal Medicine to the National Caucus and Center on Black Aged:

“D.C. was so sick that she couldn’t eat. She suffers from Crohn’s disease, chronic digestive disease of the intestines.

“To save her life, D.C.’s doctor hospitalized her for treatment with total parenteral nutrition (TPN), a technique in which a thin tube is surgically inserted into a large chest vein so a nutritious solution can be fed directly into her bloodstream. The treatment appears to be working. D.C. has gained 20 pounds over the last two weeks.

“But it’s not clear how long she will continue to receive the treatment, since D.C. lacks health insurance. And while [the state of] Virginia’s Medicaid program will pay [for] her treatment at the hospital, it will not pay for her treatment at home. And . . . her hospitalization program under Medicaid has already run out.

“This leaves D.C., her family, her doctors and the hospital with a classic dilemma: Who should pay for life-saving treatment for people with chronic illnesses who cannot afford to pay?”

We now come to a group that will increasingly be the target of this nation’s utilitarian approach to medical care—especially care for those individuals who, you know, ought to be glad they’ve come this far anyway and have a hell of a nerve expecting the rest of us to keep pumping money into their November years.

I mean, of course, the elderly. Daniel Callahan, director of the Hastings Center—the Tiffany’s of bioethical institutes—has a plan for the elderly that will certainly reduce the cost of caring for them.

In his book, *Setting Limits* (Simon and Schuster), Callahan projects a nation teeming with inconvenient ancient people:

“Those over the age of 85—the fastest growing age group in the country—are 21 times as numerous as in 1900. In 1985, for the first time in American history, the number of those over the age of 65 came to exceed those under the age of 18. In the early 1960s, less than 15 per cent of the federal budget went to those over the age of 65. By 1985, that percentage had grown to 28 per cent.

“Those over 85 . . . now 1 per cent of the population, should rise to 5 per cent by 2050, and from 9 to 24 per cent of those 65 and older.”

Why, it’ll be hard to go anywhere without stumbling over people who look like Lionel Barrymore and Margaret Rutherford. What to do? What to do?

Let us begin, says Callahan, by deciding on how a “natural life span” shall be defined. It should end somewhere, he proposes, in the late seventies or early

eighties. At that point, by congressional statute, the old person who has stayed too long will get no more from Medicare than routine treatment and the alleviation of pain and suffering.

Like the once and former coal miner in England, the elderly in America will be denied, for instance, a coronary bypass operation. (Unless they can pay for it themselves.) And the indigent old folks who are dependent solely on the state for life-extending care will also be barred from extended stays in intensive care units. And they will be prevented from having feeding tubes, among other amenities America can no longer afford.

In addition, Callahan would mandate that Medicare and other government sources of funds not pay research on life-prolonging technology that might particularly benefit the aged. The money instead should go for research into the health problems of the rest of society. The greatest research for the greatest number.

Leading into an interview with Daniel Callahan in the November 10, 1987, *Los Angeles Times*, Allan Parachini seized the attention of his readers:

“It is 20 or 30 years from now. Your mother has Osteoarthritis, a condition in which, in extreme cases, the joints—particularly the hips—deteriorate so much that they can no longer function.

“Your mother has just reached this point, but at 82 1/2 she is six months past the statutory definition of a normal life span. Joint-replacement surgery may not be offered since it is a high-cost service likely to prolong your mother’s life without a cost benefit to society.

“She cannot receive surgery, but she can be given pain relievers. Organ transplants are out of the question [because Medicare won’t pay for them under the Callahan rules].

“In today’s society, this imaginary situation would be exactly that: imaginary, perhaps unthinkable. But in the view of a prominent ethics scholar, age-based rationing of medical services must necessarily come to pass, probably, he argues, before the end of the century.”

Is this really possible? Daniel Callahan takes sardonic pleasure in telling me that practically no one has endorsed his specific way of cutting costs—limiting care for the elderly. Well, not exactly no one. I was present, with Callahan, at a Washington conference at which former Colorado governor Richard Lamm thumpingly endorsed the Callahan Plan. And that tells you something, if you remember Lamm opening the discussion in 1984 with his proposal that folks of a certain age and condition have a “duty to die.”

But it’s not only Lamm. Prestigious people in medicine have saluted Callahan’s book—with John Arras, a medical ethicist at Montefiore Hospital, calling it “a very courageous book.” In the *New York Review of Books*, Sidney Hook described it as “morally courageous.” And Ruth Macklin, a bioethicist at

the Albert Einstein College of Medicine, says solemnly: “The idea is not going to go away as long as there is a perceived need for cost containment.”

I think she has a point. This country has already agreed to certain forms of *lebensunwertes Leben* (“life unworthy of life”). It is now legal in an increasing number of states to remove feeding tubes from people purportedly in a chronic vegetative state, although they are not terminally ill or in pain. And physicians, as in *The New England Journal of Medicine*, keep protesting bitterly that they are prevented by a 1984 law from arbitrarily and silently ending the unworthy lives of certain handicapped infants. The physicians expect they will yet prevail.

We don’t have far to go, then, to set Callahan-style limits on the lives of the elderly. And when that happens, it’ll be hard to stop us and the government from sliding further down that life-unworthy-of-life slope. As the *Atlanta Constitution* said in an editorial about the Callahan way of planning for the aged:

“And what if the savings he envisions fail to materialize? Who would be sacrificed then? 70-year-olds? The disabled?”

The Prisoner Who Cannot Be Broken

Nonviolent resistance does not mean trying to disturb nothing or glossing over realities. It is the most profound kind of disturbance we seek to achieve. Nonviolence is not apathy or cowardice or passivity.

—A. J. Muste, a radical pacifist who was a key strategist in the antiwar and civil rights movements.

Pacifism taken too far can cooperate with evil by doing nothing active to resist it. The distinction being, I believe, that passive resistance always confronts evil (albeit nonviolently and with love), whereas pacifism doesn't necessarily confront or resist that evil which it opposes. Pacifism is more a state of being . . . while passive resistance is always an action.

—Joan Andrews, from her cell in Broward Correctional Institution, a maximum-security prison in Florida, where she is currently serving a five-year sentence.

Gandhi sent the term, *Satyagraha*, to pacifists around the world. It means soul-force or truth-force. The idea is that the most effective way to resist evil, and the violence with which it is maintained, is nonviolently. But actively.

Martin Luther King was, of course, the leading exemplar of *Satyagraha* in this nation. He led many actions—all of them nonviolent and all based on his conviction that the force of truth would eventually prevail even over guns, clubs, tear gas, water hoses, dogs, and centuries of hate.

As Dr. King and many of his followers learned, *Satyagraha* can be a long, hard road. Especially since, as Gandhi taught: “In war one inflicts punishment upon the adversary; in *Satyagraha*, one draws the maximum suffering on oneself without a trace of bitterness against the opponent as a human being.”

That's asking a lot, and that's why I'm an imperfect pacifist—only a nuclear pacifist. That is, I have been for unilateral American nuclear disarmament since Hiroshima; but if some person smites me, I will smite her or him back.

I have known a number of absolute pacifists; and some of them—while in prison for refusing to register for the draft—have been non-cooperators. Their consciences will not allow them to do what the murderous state, as they see it, tells them to do. Even when they are prisoners of that state.

This is the story of one such prisoner and of how the state of Florida has been trying to teach her that unless she does cooperate with her keepers, she will be broken.

What has happened to her already would, under other circumstances, be so shocking to most liberals and civil libertarians that indignant newspaper ads would be published around the country—with many prestigious signatures.

There have been no such ads, because this prisoner of conscience is a pro-lifer. Yet, Charles Oberly, attorney general of Delaware, who identifies himself as strongly “pro-choice,” told me recently that he regards what Florida is doing to this prisoner as cruel and clearly calculated to break her.

“She is not a danger to the system,” Oberly says. “She’s not going to try to escape. She’s not going to hurt anyone. Yet they keep her in solitary confinement. They won’t let her attend Mass. In Delaware, we don’t treat our most hardened criminals that way.”

The name of this incorrigible prisoner is Joan Andrews. In March 1986, she entered an unoccupied room at an abortion clinic in Pensacola, Florida. She tried to pull out the cord from a suction machine. That’s the machine which removes “the products of conception” from the uterus by sucking the tissues away from the lining of the uterus.

Joan Andrews failed to tear out the cord, but she had trespassed and she had damaged property. So she was busted. Released on bond, Joan Andrews was picketing in front of that very same abortion clinic three days later.

This practically instant recidivism—and the fact that Andrews had often been arrested before for demonstrating at places where abortions are performed—made Judge William Anderson determined to teach this woman, and presumably others like her, a lesson.

First he found her guilty of criminal mischief, burglary, and resisting arrest without violence. She was also found guilty of doing about \$200 worth of damage to that suction machine.

Then the judge asked Joan Andrews if she would promise to stop trying to obstruct the lawful—and indeed, constitutional—practice of abortion. If she made that pledge, he would grant bond again and it was possible she might get probation instead of prison time.

If a judge were to ask a mugger or an embezzler to say he or she is sorry, the courtroom would be flooded with the penitent’s tears. But a prisoner of conscience can’t lie. To tell the state a lie is to *be* a lie, and one’s conscience is then irreparably damaged goods. (This is as true of nonviolent antiwar activists as it is of nonviolent direct-action pro-lifers.)

Joan Andrews told Judge Anderson that she could not, and would not, promise to never again try “to save a child’s life.”

This, after all, is a woman who, some years ago, lost an eye to malignant melanoma. Three days after the eye was removed, she was back trying to persuade women not to enter an abortion clinic.

Judge Anderson said icily that this woman is clearly “unrepentant,” and sentenced her to five years in prison.

The same day, two men appeared before the same judge for sentencing as accomplices to a murder. They got four years. (For further comparison, it might be noted that in Vermont this year, John Zaccaro Jr. was sentenced to four months of house arrest for selling cocaine.)

Joan Andrews is a total pacifist. Although a Catholic, she does not agree, for instance, with most Catholics that some wars are “just” wars. She believes that it is impossible to call any killing “just.”

As an absolute pacifist, Joan Andrews has not cooperated with prison authorities and guards. Her resistance, of course, is entirely nonviolent. She will not sign forms or go to orientation sessions. When she has been strip searched, she goes limp.

For being a nonviolent resister, she is punished. Continually. For most of her term, she has been in solitary confinement. And she is not permitted to leave her cell to attend Mass. I checked this out with Florida prison officials a few days ago. Even though she has agreed to drop her non-cooperation for the time it would take to attend Mass, the restriction has not been removed.

One prison official emphasizes, however, that she is “allowed to pray.”

Never say that the state of Florida is without mercy.

And a priest is permitted to go to her cell and offer her communion. But Mass is more than the receiving of communion. It is also the experience of communal prayer. As priests have told me, to deny Joan Andrews the wholeness of the supreme act of worship of the Catholic faith is to do her harm.

I believe that harm is also a violation of the free exercise of religion clause of the First Amendment. Clearly, Joan Andrews’ attendance at Mass would have posed no danger to the orderly running of the Broward Correctional Institution, which, by the way, is the only maximum-security prison for women in the state of Florida.

If a pro-choice Catholic woman had been arrested for trying to obstruct Congressman Henry Hyde as he was about to draft another anti-abortion bill, would the American Civil Liberties Union have helped that woman in the event she had been imprisoned and denied the right to attend Mass?

The otherwise alert ACLU has had nothing to say about Joan Andrews. Nor have any of the established women’s rights organizations. As George Orwell used to point out, some people are just entitled to more rights than others.

Except for her offer to be a good soldier in order to attend Mass, Andrews has

persisted in her non-cooperation. After all, she emphasizes, it was Thomas Jefferson who said that all law is made to protect human life. Accordingly, she says, when the state—through the legalization of abortion—keeps on “killing babies,” she cannot cooperate with the state’s prisons that punish those trying to prevent “legalized murder.”

Most readers of the *Voice* will surely disagree with Joan Andrews’ priorities, but is the state entitled to try to crush her because of her principles?

In February 1987, Joan Andrews was transferred to the Women’s Correctional Institute in her own state of Delaware. Florida was hardly anxious to keep this practitioner of soul-force. And Delaware took her in for humanitarian reasons. Her sister and supporter, Susan Brindle, lives in that state. And it was while Joan Andrews was there that Delaware’s attorney general, Charles Oberly, got to know about her and what had happened to her in Florida.

Joan Andrews came to the conclusion, however, that she ought to be back in a cell in Florida. The state of Delaware had done nothing to her. It had been Florida that treated her unjustly, so Florida should have the burden of her imprisonment. Absolute pacifists do not make life easy for themselves, and they don’t make life easy for others, especially for people in authority.

So now she’s back at Broward. The homecoming on June 17 was brutal. Joan Andrews described it in a letter to her family:

“There was a very bad forced strip search with a male officer and about five female officers . . . As soon as I showed passive resistance, to the extent of simply clutching my clothing about myself, the male officer said I was asking for it. With that he and the others managed to pull or tear off all my clothes.” The male officer cut off some of her clothes with scissors.

“ . . . It was totally unnecessary. I had told the warden that I, as always, would remain nonviolent. I would simply grab hold of my clothing to maintain my modesty. A strip search in my case was simply a show of strength and contempt. My record clearly shows: 1) I have never used drugs, therefore there was no suspicion I had drugs (the cavity was examined). 2) I am a virgin, therefore they were not looking for signs of VD or AIDS. 3) Since it is well known I am a nonviolent pacifist, they knew I did not carry concealed weapons on me . . .

“Emotionally I feel as though I went through an attempted rape with all the brutality and degradation. . . . Because of this, I realized that my non-cooperation must [now] entail *nothing* from the prison, no care beyond the bare necessities to maintain life.”

Attorney General Charles Oberly of Delaware continues to be concerned about what is happening to Joan Andrews in Florida. There’s nothing he can do about it but speak out—and it’s rare for a prosecutor in one state to openly criticize what he regards as official injustice in another state. One Florida prison

official told me caustically that Oberly has no business saying what he did. “That’s Florida’s business.” But Oberly has a conscience.

To begin with, Charles Oberly told me, Joan Andrews’ five-year sentence was “absurd. She’s not a bomber.” And ever since Andrews has been locked up, Oberly adds, Florida “has been trying to break her. A Florida official said of her, ‘She’s going to play by our rules—or else!’”

Oberly got so frustrated at such injustice that at one point he wrote the secretary of state in Florida and asked, “Isn’t enough enough?”

I asked the same question of Florida prison officials. Their answer was that Joan Andrews is going to be kept in prison until October 1990.

And every day and every night, she’s going to be taught a lesson about what happens to people who don’t play by the rules.

Does anybody care?

How Viable Is *Roe v. Wade*?

Webster v. Reproductive Health Services is the name of a case that is causing great apprehension among the pro-abortion forces—and guarded optimism among the pro-lifers. The Supreme Court has agreed to review the case, and I have been told by the Court’s press office that oral arguments will probably be scheduled for April. That means a decision will come down by June or, if the term goes long, by early July.

The case comes out of Missouri. In 1986, the legislature passed a law intended to severely restrict abortions. There was even a preamble—a legislative finding—that life begins at conception.

Among the provisions of the statute is the banning of abortions at public hospitals or any other public facility unless the woman’s life is in danger. There is also a provision that, in my view, flatly violates the First Amendment: no public funds can be used not only for abortions but also “for encouraging or counseling a woman to have an abortion not necessary to save her life.”

Furthermore, physicians who do abortions in Missouri would have to first perform various tests to determine whether fetuses who appear to be 20 weeks or older are viable.

This goes back to the original 1973 Supreme Court decision, *Roe v. Wade*, which said that while a woman’s right to privacy gives her the accompanying right to have an abortion, the state may regulate or even prohibit abortions once the fetus is viable. That is, once the fetus is sufficiently developed so that he or she has a reasonable likelihood of surviving outside the womb—with or without artificial support.

There are two basic problems with the “viability” concept. One is that in 1973, the medical consensus was that a fetus could not be viable until he or she was between 24 and 28 weeks old. (There were a few hardy exceptions, but they decidedly were exceptions.) But 10 years later, as Sandra Day O’Connor noted (*Akron v. Akron Center for Reproductive Health*), the marvels of technology had come to the point where “the *Roe* framework . . . is clearly on a collision course with itself. . . . As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception.”

What O’Connor was saying, of course, is that thanks to science, the state would be able to regulate abortion sooner and sooner under the terms of *Roe v. Wade*. William Brennan, a strong supporter of abortion rights, foresaw this

“collision” in 1973. He urged Justice Harry Blackmun, the author of *Roe v. Wade*, not to tie the state’s interest in protecting the fetus too closely to “viability.” The fetus won’t always wait until the third trimester to be viable, Justice Brennan said, and so the viability threshold could make abortions harder to get. Blackmun was not persuaded.

The irony, however, is that “viability” died as a factor in regulating abortion on the very day *Roe v. Wade* was decided. On the same day, the Court ruled on *Doe v. Bolton*, in which Harry Blackmun, speaking again for the majority of the Court, declared that while the state had the power to limit abortion after a fetus became “viable,” it first had to consider whether an abortion was necessary anyway to preserve the “mother’s life or health.” He said that medical judgment on these matters “may be exercised in the of all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient. All these factors may relate to health.” And therefore, may allow the fetus to be destroyed.

Roe v. Wade, moreover, Blackmun, for the Court, spoke of such other psychological stresses as the pressures of child care when there are already other kids at home, unwanted children, and the stigma of unwed motherhood. These too are related to a mother’s health.

And that’s how we have abortion on demand in this country. There’s always a doctor who’ll certify it’s necessary for the mother’s health. Few abortions take place in the third trimester, but it can be lawful to abort on the very eve of birth.

So Justice Brennan needn’t have worried. A “viable” fetus has essentially no more protection from the state than an embryo.

Anyway, getting back to Missouri’s strictures on abortion, the law was supposed to go into effect in August 1986, but it was challenged by two abortion clinics, Reproductive Health Services in St. Louis and Planned Parenthood in Kansas City. Also part of the suit—in view of the prohibitions the statute placed on public employees—were a publicly employed social worker, a nurse, and three physicians.

In March 1987, a federal district judge in Kansas City declared the major sections of the statute to be unconstitutional infringements of *Roe v. Wade* as well as of subsequent pro-abortion Supreme Court decisions. In July 1987, a three-judge panel of the Eighth Circuit Court of Appeals agreed, for the most part, with the lower court.

Now we get to the question of why the Supreme Court would want to review *Webster v. Reproductive Health Services*. (William Webster is the attorney general of Missouri, and it should be noted that in his appeal to the Supreme Court, Webster said that if the Missouri statute is found to be unconstitutional under *Roe v. Wade* and its progeny, the Court should consider whether *Roe v. Wade* itself is constitutional.)

On September 13, 1987, Harry Blackmun, talking to a group of law students, predicted that his most renowned achievement on the Court, *Roe v. Wade*, “could go down the drain . . . this term. You can count the votes.”

It may be presumptuous of me, but I do not agree with Blackmun that *Roe v. Wade* will be shot down this term. Eventually, it will be, but not now. The Missouri case is probably going to be the beginning of the end for the constitutional right to have an abortion on demand, but it is not the end of that right.

Let’s look at the votes. Four Justices unshakably support the right to an abortion: Blackmun, William Brennan, Thurgood Marshall, and John Paul Stevens. On the other side are the original two dissenters in *Roe v. Wade*: Byron White and William Rehnquist. They have not changed their minds. The fact that Rehnquist has since become Chief Justice gives him weight. The Chief, if he is in the majority on a case, has the power to decide who will write the opinion for the Court. He can either assign it to himself or to a Justice he feels will shape it the way the Chief wants it shaped. If there is a majority to affirm the Missouri restrictions on abortion, Rehnquist is likely to see to it that the language of the opinion will send a resounding message to other state legislatures that they can go ahead, if they like, and impose their own restrictions on abortion.

Not on the Court in 1973 were Sandra Day O’Connor, Antonin Scalia, and Anthony Kennedy. O’Connor has been increasingly critical of *Roe v. Wade*. She is a cautious jurist, however, and is not likely—yet—to vote to scrap that landmark decision. She is very likely to approve of restrictions on abortions, and has in the past.

Scalia, by temperament and conviction, is not a main-streamer among so-called conservatives on the court. He likes to leap where his logic leads him, and I would count on him as a definite vote to overturn *Roe v. Wade*, in this case.

Anthony Kennedy, it is generally believed, will be the swing vote in the Missouri case—and in future abortion cases so long as the present membership of the Court remains intact. On most of the key issues so far, Kennedy has been to the right of the Court’s center. Since O’Connor is that center, it is hardly on the 50-yard line.

Kennedy—I have been told by sources in California who have been accurate in the past—helped draft pro-life legislation before he became a judge out there. Maybe he’s changed his mind since then, but I doubt it. On the other hand, like O’Connor, he is not one for bold moves. So Kennedy is likely to join a majority to vote to overturn the lower courts that struck down the Missouri restrictions on abortions. If a majority later overturns *Roe v. Wade*, he’ll jog along.

The eventual leader of that majority is likely to be the Chief. Rehnquist, after being the Lone Ranger during much of his first term as Chief Justice, has learned how to “mass the Court”—forge a majority—on important issues. My guess is

that he may wait for a full assault on *Roe v. Wade* until one or more of the three Justices over 80 (Brennan, Marshall, and Blackmun) retire. In view of the impact a reversal of *Roe v. Wade* will have on the country—mass protests and long-term civil disobedience—Rehnquist may prefer to have a 7 to 2 or an 8 to 1 vote with which to abolish the constitutional right to abortion.

As for now, in order to review the Missouri case—or any other—four justices had to vote to grant *certiorari*. Those votes did not come, I would think, from Blackmun, Brennan, Marshall, and Stevens. Their point of view had already won when the lower courts scuttled the Missouri anti-abortion law. What did they have to gain by bringing the case up to the Court? Especially with Anthony Kennedy now in place of Lewis Powell, who believed in abortion rights.

And that is why the pro-abortion forces are right to be apprehensive, are planning large-scale demonstrations and barrages of mail to tell it in no uncertain terms that it will be going against the popular will and justice and fairness if it weakens *Roe v. Wade* in any way in deciding this most unwelcome case from Missouri.

However the Court decides, this kind of public-relations assault—as contrasted with sending in strong *amicus* briefs that can be influential—may boomerang. The one thing that unites all members of the Court is their deep sense that when they decide constitutional issues, polls and plebiscites lobbying must be excluded. If the Court went by popular will, there wouldn't have been a *Miranda* decision, an exclusionary rule, the declaration public segregated schools are unconstitutional, and the holding that residential covenants barring blacks and Jews are also unconstitutional.

I was in the Court one day when a huge demonstration was going on out front against the appalling *Hardwick* decision (largely removing homosexuals from the protection of the Bill of Rights). Over 600 people were arrested right in front of the Court, cops were all over the place, and the chants could be heard in the marble halls.

In those halls, in the Justice's chambers, and later, in the courtroom where oral arguments went on as scheduled, no attention was paid to the fury outside. It had no impact.

Dred Scott, Abortion, and Jesse Jackson

. . . *human kind cannot bear very much reality.*

—Burnt Norton, T .S. Eliot

Two of the clearest distillations of a woman's right to an abortion appeared in a January 29 New York *Times* editorial and a February 4 letter to the Washington *Post*. Said the *Times*: "Strip the issue of rhetoric . . . and it comes down to a simple question: Does society have the right to force a woman to incubate a fetus against her will?"

In the Washington *Post* letter, Kate Michelman and Dawn Johnsen of the National Abortion Rights Action League quoted from a 1986 ruling by the Supreme Court: "Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision . . . whether to end her pregnancy."

You will notice that the fetus is mentioned only as something that can be disposed of by decision of the mother. This means, of course, that the fetus is not a "person" under the Constitution. It has no rights under the Constitution. If he or she had rights, the 14th Amendment would save the fetus from being executed: ". . . nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

A while ago, I discussed this matter with a Justice of the United States Supreme Court (not Harry Blackmun). He knows that I am pro-life, and he knows that I am an atheist, so no religious underbrush had to be cleared away.

"Soon after conception," I said, "there emerges a distinct human identity—a unique constellation of genes and chromosomes, unlike any human being before or after. Obviously, this is a developing being, but he or she certainly is human. Yet you and a majority of the Court keep on saying that the fetus has no constitutional rights."

"I know the argument," the Justice said. "I've heard it many, many times. I can assure you there was considerable discussion of just that point when *Roe v. Wade* was written, and after. But the fact is that the Constitution defines a 'person' as someone *born*. Obviously, Nat, the fetus is not born until it is delivered."

And there it is—the same reasoning—in Harry Blackmun's 1973 majority opinion in *Roe v. Wade*. Blackmun said that if the "personhood" of the fetus

were established, its “right to life would then be specifically guaranteed by the [14th] Amendment.” But, said Blackmun, there is no previous case “that holds that a fetus is a person within the meaning of the 14th Amendment.”

He pointed to the three places in the 14th Amendment where the word *person* appears. As we’ve seen, it’s in the due-process clause, and in the guarantee of equal protection of the laws. The other place—and this was probably the convincer for Blackmun—is in this line: “All persons born or naturalized in the United States . . . are citizens of the United States and of the State wherein they reside.”

So, said Blackmun, “the word *person* as used in the 14th Amendment, does not include the unborn.”

A woman’s right of privacy to abort would not be enough without that ruling that the fetus is a non-person.

Once before, in 1857, the Supreme Court also excluded an entire class of living beings from the protection of the Constitution. In the *Dred Scott* case (1857), Chief Justice Roger Taney emphasized that those of African descent, whether free or slaves, had “never been regarded as a part of the people or citizens of the State.” They “had no rights or privileges but such as those who had the power, and the Government, might choose to grant them.”

Accordingly, people of African descent were not “persons” under the Constitution. They were private property. Their owners could do whatever they pleased with them. (Just as now—*Times*, December 25, 1988—women are increasingly undergoing prenatal testing to find out the gender of the developing property inside them. If the gender is the wrong one, the fetus is destroyed.)

The Abolitionists—the civil rights workers of the 19th century—fiercely fought against the horrendous consequences of that rule of law—as distilled at New York’s Academy of Music in 1859 by Charles O’Conor:

“As a white nation, we made our Constitution and our laws, vesting all political rights in that race. They, and they alone, constituted, in every political sense, the American people.”

And that other nation, though it breathed and felt pain, a lot of pain, was not a people at all. It consisted only of clumps of property. Owned in privacy. And when killed in privacy, that was no one else’s business but the owner’s.

In this century, a renowned civil rights leader used to say that he had a very personal interest in abortion: “I was born out of wedlock and against the advice that my mother received from her doctor.”

He also had a personal interest in the argument that a constitutional right to privacy justified killing a developing human being. In 1977, Jesse Jackson wrote:

“There are those who argue that the right to privacy is of a higher order than the right to life . . . That was the premise of slavery. You could not protest the existence or treatment of slaves on the plantation because that was private and

therefore outside of your right to be concerned.”

Jackson, in addition, was much intrigued by what he called “the psycholinguistics of abortion—finding a parallel between pro-abortion newspeak and the masking of the actual intent of language in matters of race.

“If,” said Jackson, “something can be dehumanized through the rhetoric used to describe it, then the major battle has been won . . . That is why the Constitution called us three-fifths human and then whites further dehumanized us by calling us ‘niggers.’ The first step was to distort the image of us as human beings in order to justify that which they wanted to do and not even feel like they had done anything wrong. Those advocates of taking life prior to birth do not call it killing or murder, they call it abortion.”

In the 1970s, Jackson, moreover, thought way ahead of most of the rest of the right-to-life movement. He was prescient enough to make the connection between the death-by-privacy that had been made constitutional in *Roe v. Wade* and the coming use of that very same decision to justify euthanasia at any stage of life after birth. (And so it came to pass last year in *Gray v. Romeo*, when a federal district judge used *Roe v. Wade* to end the life of a woman who was not terminally ill but whose husband and children thought would be better off dead.)

The logic of abortion, Jesse Jackson wrote, could lead to “killing . . . other forms of incompleteness . . . crippleness, old age.”

Jesse Jackson is no longer a pro-lifer. It may be a genuine conversion, or it may have had something to do with his decision to run for national office. It figured that he would have lost the votes of many liberals if he had kept talking—as he did in 1978—about “defending human life in its most defenceless state, in its unborn condition, where it is so inhumanly exploited by abortion.”

You don’t hear Jesse saying that anymore. But on January 23, he was one of 13 distinguished civil rights leaders who were assembled by Planned Parenthood to sign a statement excoriating those pro-lifers—particularly the Operation Rescue forces—who have the utter gall to claim they have a moral connection with the traditions of the civil rights movement. Why, these singing protesters—said the 13 signers—are more like the segregationists who fought desperately to block black Americans from access to their rights.

Among the accusatory 13 were: Julian Bond; James Farmer; John Jacob, president of the National Urban League; Mary King, author of *Freedom Song: A Personal History of the 1960s Civil Rights Movement*; Dr. Joyce Ladner, former field secretary, Student Nonviolent Coordinating Committee; Roger Wilkins; and Andrew Young.

These civil rights leaders attacked the pro-lifers for trying to “deny Americans their constitutional right to freedom of choice. They want the constitution rewritten.”

So did the Abolitionists. And these very 20th century civil rights leaders

fought ceaselessly to deny racist whites their freedom of choice to segregate just about everything in sight. And where there were laws saying that whites had that privacy right to exclude blacks, those in the civil rights movement marched and demonstrated and blocked entrances and eventually brought new life to the Constitution.

Obviously, the pro-lifers have different goals but their means are similar. And from their perspective, they too are engaged in a massive civil rights movement, for there have been some 20 million developing human beings—as Jesse Jackson used to say—killed since *Roe v. Wade*.

There has been isolated, utterly indefensible violence—as in the bombings of clinics—that could have killed people. But nonviolence is both the principle and strategy of such groups as Operation Rescue. They know that if they are associated with violence, they will have greatly strengthened the pro-abortionists.

There has indeed been violence at some Operation Rescue demonstrations, but it has been violence inflicted on those pro-lifers by the police—most viciously in Atlanta, where Andrew Young is mayor. One of the members of the Atlanta City Council is Hosea Williams who, like Young, was a close associate of Martin Luther King. When he saw what the cops were doing, Hosea Williams said:

“We who were the leaders of the movement in the ’50s and ’60s are now political leaders. And we are doing the same thing to demonstrators that George Wallace and Bull Connor did to us.”

But these demonstrators are “zealots,” as a Boston *Phoenix* reporter calls pro-lifers who block entrances to what they regard as places where developing human beings are being killed.

Professor Mary Ann Glendon of Harvard Law School, author of *Abortion and Divorce in Western Law* (Harvard University Press), spoke—during a recent conversation with Bill Moyers on public television—of what she calls “developing life—what the Supreme Court of the United States has refused to call either human or alive or a person. Somehow the [whole] story [of abortion] has got to take account of that.”

This doesn’t mean that abortion is never necessary. It was called for, however sadly, in the recent Long Island case in which the husband of a pregnant woman in a coma fought to become her guardian so he could authorize an abortion. Medical opinion was divided in this case, but since the mother, without an abortion, might have been at further risk of death, her life had precedence. By contrast, the vast majority of abortions are not performed to save the mother’s life.

The Painful Education of a Schoolteacher

For 19 years, Linda Thayer has been teaching in Boston in what outsiders call inner-city schools. She has had students who have killed people, and the passage to and from her school sometimes has its perils.

“Yet,” she told me recently, “I feel safer there than I did last June among the police of West Hartford, Connecticut.”

Thayer was among 261 people arrested on June 17 during an Operation Rescue invasion of an abortion clinic in West Hartford. She had come to picket, not to go inside, but she was swept up too. Like many of those arrested and held in custody, she says she was not allowed to see a lawyer for two days and was subjected to “pain-compliance” techniques that a number of police departments around the country have been developing.

Thayer, like others of the protesters, went limp—a traditional method of passive resistance often used in the peace and civil rights movements. “Pain-compliance—the bending of wrists and fingers, the use of pressure holds and various other ways of inflicting pain so unbearable that the prisoner finally does what he or she is told—does get people to walk.

Clearly, those of the prisoners who had tried to take over the operating rooms of the abortion center had broken the law and had to be arrested. But does passive resistance give the police, in turn, the right to use torture? (And what is torture but making pain so excruciating that the prisoner succumbs?)

There was need to transport the prisoners, but no need to subdue them. Mark Jahne, the managing editor of the West Hartford News told me: “The protesters did not fight back. Nobody took a swing at an officer.”

The police who descended on Thayer and the others had taken off their badges and name tags. The official explanation was that they didn’t want the prisoners to be scratched.

And indeed, Thayer was not scratched. But in custody, lying face down on the ground, her wrist was pressed forward by a policeman until she screamed. Handcuffs were put on, and although her wrist had started to swell, the officer pulled the cuffs even tighter, she says, until the pain was such that she screamed again. Many were screaming that day. One elderly white woman said later, “I really identify now with blacks who charge police brutality. If I happened to be black, it might have been worse.”

After having seen a videotape of some of the police action and after having talked to others arrested, I read many affidavits, court papers on both sides and

police statements. Among the latter was one by West Hartford Police Chief Robert McCue: “I’m proud of the professionalism shown by my officers all during this incident.”

On the other hand, there are the very real screams I heard on the tape. “Most frightening,” says Thayer, “was the realization that the people we trust to enforce the law—the people whom we give power over us—can abuse it without any public outcry. When that happens to *anything*, right or left, we give government license to later inflict brutality on any group they choose.”

There was no public outcry. The town council of West Hartford thumpingly supported what the police had done. And civil libertarians were silent. But if the same police techniques had been applied to anti-apartheid demonstrators who had taken over the offices of a company dealing with South Africa, there would have been indignant marches right up to the doors of the police department.

People involved in Operation Rescue, however, are pariahs—shunned even by the National Right to Life Committee, which embodies the mainstream of the pro-life movement. Those in favor of abortion rights despise them. While she was being dragged along, in terrible pain, Thayer remembers “seeing the pro-choicers screaming at me. The hateful look on their faces. I can’t understand people who are thrilled at *anyone* being abused in this way.”

It was the conviction of Earl Warren that “justice can be realized whenever those who are not injured by injustice are as outraged as those who are.”

This is not one of those times. The Boston schoolteacher says, “I did not think I was in this country. I had never seen the infliction of pain on people in so systematic a way.”

One prisoner yelled, “You broke my wrist!”—which turned out to be the case. “The officers,” he said, “continued to pull up on it even harder.”

And not a minister or a rabbi in West Hartford has said a public word about what happened that day.

Two Cheers for the ACLU

In the year of its 70th anniversary, the American Civil Liberties Union is flourishing. In part because of its most effective ever membership director—George Bush in the 1988 campaign—its card-carrying members have risen to more than 275,000, the ACLU's highest yet.

A new history of the ACLU, "In Defense of American Liberties," by one of its national board members, Samuel Walker, has received enthusiastic reviews. The New York *Times* critic said the book reminds us that "the ACLU remains a national treasure" because of its historic defense of unpopular views.

It is indeed a national treasure, but in some respects the organization is turning zealously majoritarian. There has been for instance, a change in the ACLU's priorities that has made abortion rights its most intense concern. This can be seen in the placement and fervor of pro-choice stories in the newsletters of many of its affiliates and in the ACLU's own membership publication, *Civil Liberties*. There are times when the ACLU seems to have become a subsidiary of the National Abortion Rights Action League.

On the national level, moreover, even opposition to the death penalty—long a primary concern—has been made subservient to abortion.

In its 1986-87 term, the Supreme Court reviewed the case of William Wayne Thompson, who was on death row in Oklahoma for having committed a murder when he was 15. Because Thompson had been so young, opponents of laws in those states that allowed the execution of juveniles thought this might be the case that would convince the court to overturn those laws.

Henry Schwarzchild, head of the ACLU's Capital Punishment Project, prepared a brief arguing that a 15-year-old is not as mentally, emotionally or morally capable as an adult of understanding the consequences of his acts. But the brief was never filed because Janet Benshoof, director of the ACLU's Reproductive Freedom Project, strenuously objected. Since she argues before the Supreme Court that teenage girls are mature enough to decide whether to have abortions—without having to inform or obtain the consent of their parents—Schwarzchild's argument would weaken hers.

A civil rights attorney told me, "I'm against parental consent and notification before an abortion, but if I have to choose, I'd much prefer to try to save a teenager from the electric chair."

And Charles Ogletree, former trial chief in the Washington, D.C., public defenders' office and now a Harvard Law School professor, said recently: "I

was surprised and sorely disappointed that one of the most powerful advocates of children's rights caved in on so important an issue, particularly at a time when many states are grappling with it."

The ACLU, by the way, believes the privacy right that protects any decision a woman chooses to make about childbearing also extends to euthanasia—an increasingly popular position according to the polls. Accordingly, the ACLU provided the lawyer, William Colby, for the Cruzan family in this term's "right to die" case.

Colby dutifully noted in oral argument before the Supreme Court that due process would be a nice thing to have before the incompetent patient was killed. But the essence of his argument was that life-or-death decisions should essentially be made by the family.

The ACLU agrees, as it did in all but one case concerning severely handicapped infants. To the ACLU, Baby Does, though born, have no meaningful rights of their own to equal protection and due process. The parents' privacy rights must prevail against government intervention on behalf of the child—as if the infant were property.

The ACLU has become so near-absolutist regarding privacy that it opposes mandatory confidential reporting of the names of those infected with the AIDS virus so that their partners can be told if they're at risk. I asked ACLU Executive Director Ira Glasser about all the unprotected people who may be infected or may become infected because they don't know if their partners are. His answer was that all these unaware people do not pose a civil liberties issue because the government is not preventing anyone from being tested. People ought to know enough to be tested, and if they don't, too bad.

But now, the National Institutes of Health reports a rapid increase in tuberculosis, especially among those infected with the AIDS virus. And tuberculosis can be spread when an infected person coughs. Therefore, the NIH and the Center for Disease Control are urging the return of mandatory reporting of the names of anyone infected with TB so that others will know they might have been exposed.

The ACLU may well see this recommendation as yet another possible, covert invasion of privacy of those infected with AIDS as well as TB. In its 70th year, the ACLU has largely stopped testing itself. That is, it has stopped thinking of the bare possibility that it might at times have lost its way. Like many worthy organizations, the ACLU is becoming an icon to itself.

Changing the Odds

I'm so sick of being called religious radicals. We're Americans—simple, normal people.

—Cindy Burgess, a Minnesota farmer at Rally '90, Washington, D.C. (*New York Times*, April 29).

You can't just clean up a problem by killing an innocent victim. Abortion doesn't provide poor women with a job, a home, or with groceries. I honestly believe that abortion makes women weaker because it allows them to destroy their own flesh and blood without thinking about the ramifications.

—Maria Master, a Columbia University sophomore and head of Columbia Coalition for Life, at Rally '90, Washington, D.C. (*New York Times*, April 29).

IN HIS TROMBONE TONES, conservative analyst Kevin Phillips said on national television the day after Rally '90 that “the anti-abortion movement is past its prime. It's on a downtrend.”

Yet, Olivia Gans of the National Right to Life Committee proclaimed at the rally: “We are not losing! We are *winning!*”

Then why are so many once-and-former “pro-life” politicians plea-bargaining with the forces of death?

The politicians aren't the basic problem, though. They're responding to what they think their constituencies want. And as Cardinal John O'Connor has said, pro-lifers have not been effective in making inescapably clear to those constituents that “a human life is a human life.”

They have also allowed the other side to get away with the kind of prejudices and distortions that—if exposed—would make many Americans queasy at being allied with such propagandists of bigotry.

Consider, for instance, a full-page ad in the *New York Times* (April 22) by the National Abortion Rights Action League. The ad is a distillation of the main arguments of the pro-abortionists (not only NARAL). And these arguments have been very effective in the confusion following the *Webster* decision.

The ad begins with the familiar fanfare: “Who Decides? Bishops? Politicians? Or You?” Bishops lead the list of those who would assault the privacy of

women. As is later evident in the ad, they mean *Catholic* bishops. Part of the pro-abortion strategy is to bring back the specter of the Pope running America. The anti-Catholicism is as old as Samuel Adams's warnings against Papists.

For years, the other side has engaged in this not-very-subtle anti-Catholicism by more than implying that the pro-life movement is dominated by the Catholic Church and that its reason for being is to impose Catholic theology on the rest of us.

As in the vintage anti-Catholicism of the 19th and early 20th centuries, the NARAL ad used *allegedly* direct quotes to show the fell designs of the Church.

Watch this: "The National Conference of Catholic Bishops has just announced it will seek 'to impose its will directly' on the American people by contracting with Hill and Knowlton—a giant public relations firm—to craft a \$5 million dollar campaign to alter the political climate on abortion."

Any way you look at the inner quote—"to impose its will directly"—it has to be attributed to the National Conference of Catholic Bishops. But there is no way the Conference or any bishop would say that. Indeed they jump backward through narrow hoops to say that this is *not* their intention. Persuade, yes, in the marketplace of ideas. But not impose. This slippery quote feeds on the notion that the pro-life movement is part of a sinister conspiracy directed from the Vatican.

There is indeed a degree of anti-Catholicism in the nation—as there is of anti-Semitism and racism—but most Americans are uncomfortable at being associated with any group or person that maliciously plays on these prejudices.

Yet the pro-life movement has not sufficiently and persistently illuminated this sleazy element of pro-abortion propaganda, which pervades the *Times* ad, for instance in another familiar—and effective—argument by the death-as-a-choice side. Our "historical separation of church and state" is endangered, the ad claims, when attempts are made "to enshrine" a "theological perspective in our nation's laws." It's just another version of the "black-clad minions of the Vatican trying to impose their will on the American people" theme.

The concept of church and state being separate, but not adversaries, is in the First Amendment's Establishment Clause: the state cannot prefer or support any or all religions. But *only* the state can violate that clause. Bishops or rabbis or ministers can advocate whatever they please. That's why a good many Protestant churches and Jewish religious organizations have vigorously supported pro-abortion causes. Yet they are not charged with violating the Establishment Clause.

Anti-abortionists have been negligent in not pointing out—in ads, in Op-Ed page articles, in letters-to-the-editor, and in other forms of communication—just what the Establishment Clause actually is. Nor have they emphasized how sad it is that the pro-abortionists feel they have to distort the Constitution to try

to impose *their* views on the American people.

NARAL also instructs the American people that “the central question in the abortion rights debate” is: “Who Decides in America?” No, that’s not the central question. A young woman from Staten Island, Maria Claps, focused right on the central question at Rally ’90: “To me, it’s not a thing of religion. It’s so obvious a baby is alive in the womb.”

That baby should be brought directly to the attention of the cadre of Republicans—led by fundraiser Ann Stone—who are trying to generate pressure to get the anti-abortion plank out of the Republican platform. Ann Stone and the others should be asked whether they do indeed consider it civilized to kill that baby. The Democratic Party also, of course, ought to be asked the same question.

The Stone cadre will respond with some kind of newspeak about choice being the American way (like the choice to abuse a child?). But then they, and others like them in both parties, should be asked whether they feel at ease being part of a movement that spreads anti-Catholicism and misleads the gullible as to the meaning of the First Amendment.

The propaganda in all the anti-life ads stresses the alleged narrowness of the pro-life movement. (“A loud minority,” Kate Michelman says). It’s almost entirely Catholic, they imply, led by men who look like Jesse Helms but are to his right. The pro-lifers exemplify, according to the propaganda, Rep. Barney Frank’s line: “They’re pro-life, but only up to the point of birth.”

Pro-lifers have been remiss in not spreading the word about their diversity and about their increasing support of women throughout their pregnancies and after—women who might have had an abortion *without* that support.

Moreover, I’ve seen in ads and speeches by pro-abortionists the supposedly crushing point that people who say they are for life also overwhelmingly support the death penalty. Well, polls indicate that a majority of pro-lifers do not support the death penalty. When I speak at pro-life meetings, I invariably bring up capital punishment. I’ve yet to speak before a group where a majority supports this kind of killing by the state. In fact, when I spoke recently before the Delaware Pro-Life organization, much of the audience rose and applauded when I spoke of my own opposition to capital punishment.

This is not to say that there aren’t a good many pro-lifers who are convinced of the necessity of capital punishment. (“These are not innocent lives.”) But there is a diversity in the movement on this and other matters. Just about all religions are represented, for further example, and I’ve come across some of my fellow atheists.

Yet, the stereotype of pro-lifers—ardently propagated by NARAL *et al* is widely believed because it has not been effectively countered.

Much more should be known, for example, of Feminists for Life of America—

an organization of highly knowledgeable women, mostly liberal, many with experience in the anti-war and anti-nuke movements, and far wittier than their opponents.

One of them, Frederica Mathews-Green, a Vice-President for Communications, spoke at the College of William and Mary recently. Her theme: “Pro-woman, Pro-life: Feminism and Abortion.”

As printed in *The Remnant*, an alternative student newspaper at the college, there was this passage. (Had I the money, I would give it to Feminists for Life of America so they could print it in a New York *Times* ad, preferably right alongside one of the choice-to-kill ads):

A woman with an unplanned pregnancy faces more than “inconvenience.” Many adversities, financial and social, at school, at work, and at home confront her. Our mistake was in looking at these problems and deciding that the fault lay with the woman, that she should be the one to change. We focused on her swelling belly, not the discrimination that had made her so desperate. We advised her, “Go have this operation and you’ll fit right in.” What a choice we made for her. She climbs onto a clinic table and endures a violation deeper than rape—the nurse’s hand is wet with her tears—then is grateful to pay for it, grateful to be adapted to the social machine that rejected her when pregnant. And the machine grinds on, rejecting her pregnant sisters.

It is a cruel joke to call this a woman’s “choice.”

If we refused to choose, if we insisted on keeping both our lives and our bodies intact, what changes would our communities have to make? What would make abortions unnecessary?

Flexible school situations, freedom from stigma, fairness in hiring, more flex-time, part-time jobs, better access to prenatal and obstetric care, attractive adoption opportunities, a whole garden of safe family planning choices, support in learning how to handle our sex lives responsibly, and help with child care and parenting when we choose to keep our babies; this is a partial list. *Yet these changes will never come so long as we’re lying down on abortion tables. . . .* For over a hundred years, feminists have warned us that abortion is a form of violence and oppression against women and their children. They called it “child murder” (Susan B. Anthony), “degrading to women” (Elizabeth Cady Stanton), . . . and “a disowning of feminine values” (Simone de Beauvoir). How have we lost this wisdom?

That’s a pro-life voice that many people will pay attention to. She does not speak for all pro-lifers, but she speaks for many women, especially younger women, in the pro-life ranks. Voices like hers should be heard more widely.

Obviously, a crucial element in the strategy to defeat the impression that “the anti-abortion movement is past its prime” is to emphasize that it is a human being who is being executed. The “choice” is like that in the Roman arena—thumbs down.

On *Nightline*, earlier this year, a seventeen-year-old who had had an abortion was asked if she’d had any doubts, any emotional problems, afterwards. “No,” she said, looking down at where the abortion had been performed. “There was no life in there.”

I remember that photographs of the doomed developing human being used to be practically omnipresent at pro-life booths, in ads, at sidewalk tables. I still see some, but not as many as before, and that’s a mistake.

As Dr. Joel Hylton, a physician in Thomasville, North Carolina, wrote in a letter to the *Journal of the American Medical Association* (February 18, 1990):

Who can say that the fetus is not alive and is not a separate genetic entity? Its humanity . . . also cannot be questioned scientifically. It is certainly of no other species. That it is dependent on another makes it qualitatively no different from countless other humans outside the womb . . .

It strikes me that to argue that one may take an innocent life to preserve the quality of life of another is cold and carries utilitarianism to an obscene extreme. Nowhere else in our society is this permitted or even thinkable, though abortion sets a frightening precedent.

Anti-abortionists should show the humanity of some of the millions of beings killed every year. Showing the photographs of the developing human beings—and also the photographs of those who have been “terminated”—can’t help but make the undecided feel awful. And that state is often the beginning of feeling much better by being more human yourself.

Television won’t show photographs of the corpses, nor will most newspapers. They should be asked, often, why they won’t, since abortion is, after all, a political issue of remarkable magnitude and it will become even more so. To decide democratically, the populace should be informed, shouldn’t it? The media has no problem showing photos of gruesome drug killings—so why balk at these killings?

The populace also ought to be enlightened as to the growing emphasis within the pro-abortion leadership, on abortion as a form of population control. Which segments of the society are to be kept within limits? Why, the poor, of course, very much including the black poor.

Molly Yard has warned that if population rises at its present rate, there will be catastrophe. And Geraldine Ferraro, in the *New York Times*, followed right along:

Teenage pregnancies beget teenage pregnancies. Welfare mothers beget wel-

fare mothers. How much education and training must be given to break the cycle? How will housing be made available? What about schools? Where will the money come from?

So the slogan “Who Will Decide?” is being expanded to: “Who Is Not Good Enough to Be Born?” Propagating abortion has now become a public-service responsibility—to keep thinning out the ghettos.

This is also useful information for the public to know—especially for those in the public who live in the ghettos. The pro-life side has been too kind and gentle in this battle. The truth is usually neither.

Covering Up Destructive Abortions

“Sunlight,” said Louis Brandeis, “is the best disinfectant.” And that is what journalism is supposedly all about. Compelling proof of the value of this kind of sunlight was a piece, “Abortion Clinic,” on the April 21 edition of *60 Minutes*.

Reporter Meredith Vieira and producer Jane Stone provided a rather rare look at a scandal with national implications—abortions that are legal (under *Roe v. Wade*) but are not safe, and can be deadly. Also central to the *60 Minutes* story, and others like it around the country, is the refusal of certain pro-choice leaders to sound the alarm about dangerous abortion clinics lest bad publicity hurt the pro-choice cause.

Meredith Vieira began her report with Suzanne Logan who now “lives in a Baltimore nursing home. She is almost completely paralyzed. Her brain is so damaged she will never speak again. She is now 33, and will spend the rest of her life never understanding what happened to her.”

Suzanne Logan is in this condition, Vieira explained, because she went to “what she believed to be a reputable clinic where she could get a legal, safe abortion.” That was two years ago when, working as a waitress, she found out she was pregnant.

For the abortion, she went to the Hillview Women’s Medical Surgical Center in Suitland, Maryland. The fee: \$400. Shortly after she was given general anesthesia, Logan—according to her attorney Patrick Malone—stopped breathing. There was no anesthesiologist present, so there had been no monitoring.

Responding to a 911 call, paramedics—Vieira reported—found “the clinic in chaos. Hillview workers lacked the right medicine to reverse the effect of the anesthesia. Their emergency equipment was broken, causing Suzanne’s brain to go without oxygen for 12 minutes.”

The owner of this abortion clinic is Barbara Lofton. She is described by *60 Minutes*:

“For years, Lofton posed as a psychologist and ran mental health clinics until the District of Columbia shut her down for submitting phony Medicaid bills, and letting unqualified employees dispense medicine. Undeterred, Lofton went into the abortion business. But D.C. investigators again shut her down, this time for operating without a license.

“A few months later, she moved the clinic two miles across the state line to Maryland, *where there are no laws regulating abortion clinics.*” (Emphasis added.)

Indeed, in only 11 (!) states are there statutes regulating abortion clinics. A few other states supposedly oversee the clinics administratively. In fact, whether

by statute or administrative regulations, rules for abortion clinics are not, by and large, carefully enforced in many of those states. And in the great majority of states, the clinics are not regulated.

I do not recall hearing Kate Michelman, Faye Wattleton, or leaders of NOW urgently calling for the states to ensure that abortions in clinics are safe. Such a campaign would get in the way of their continual contrast between pre-1973 back-alley and coat-hanger abortions and how assuredly safe women are when they now go for abortions.

Back at Hillview, Barbara Lofton, who is not a doctor, nonetheless—according to Tony Moore, who used to work at the clinic—wore an expensive stethoscope and introduced herself as Dr. Lofton.

When the licensed physicians—who performed up to 25 abortions a day—were not around, Lofton took their place. Says Brenda Davis, who also used to work at the clinic, Lofton performed such medical procedures as “pelvic exams, cultures, [and she] prescribed medicine.”

Also on *60 Minutes* was “Elizabeth,” who asked that her identity be disguised. She is suing the clinic for a botched abortion. So may Linda Brown. Her companion, Herb Polcher, tells what happened when he came to pick her up at the clinic. “Dr.” Lofton was waiting for him:

“She said, ‘We have problems, accidentally hit an artery.’ So I went in the back, and they had the sheet wrapped around her bottom, like a baby diaper, and she was just . . . blood everywhere. . . . She was just laying there in her own blood.”

By the time she was in a hospital, Linda Brown had almost bled to death. “To save her life”—Meredith Vieira told the 30,000,000 viewers of *60 Minutes*—“doctors performed an emergency hysterectomy. She was 19.”

She will never be able to have a child.

Barbara Lofton’s response was: “No matter how good you are, accidents occur.”

In a deposition, shown on the program, Suzanne Logan’s attorney, Patrick Malone, asked the proprietor of this caring institution if there had been “accidents” before the one that befell Linda Brown.

“One,” said Lofton.

“And that involved a death, did it not?”

“It did, in fact,” said Lofton.

The dead woman was Debra Gray. Says her sister, Pam:

“The outcome was just like a back-alley abortion.”

Debra Gray paid \$200 extra to be put to sleep, under general anesthesia. While under anesthesia, her heart stopped, and she never awakened. Not surprisingly, Barbara Lofton would not talk to Meredith Vieira. But, dig this:

“Initially, neither did any of the abortion-rights activists we contacted.” Vieira continued: “As a reporter, *I found that many pro-choice leaders knew about*

problems at Hillview, but didn't want them publicized." (Emphasis added.)

(By the way, Hillview is still operating and is performing abortions as late as the 28th week. Women come from all over, CBS producer Jane Stone told me.)

At last, Barbara Radford, head of the National Abortion Federation—the professional association for the abortion industry—did go on camera, and she said: "Well, I think your first reaction from us was this is the last thing we need. *We had hoped that it wouldn't get national publicity because of the political nature of all of this.*" (Emphasis added.)

What Radford stressed was "the political nature" of the publicity coming from this terrifyingly unsafe abortion clinic. Not a word about the possible dangers to some women who—if it had not been for *60 Minutes*—would have gone to Hillview.

For that matter, not everybody watched *60 Minutes*, and one would think that a responsible, caring pro-choice leadership would try as hard as it could to get the news about this clinic spread as widely as possible. As well as the news about other such clinics in other states. For instance, appalling abortion clinic practices and conditions in Florida, Missouri, and Illinois, among other states.

And, as a vital way of safeguarding women who go for abortions in the future, one would think the pro-choice leadership would be mobilizing press and legislative support around the country for meaningful regulation of abortion clinics.

Yet, despite what they know about the Hillview clinic in Maryland, and other such clinics elsewhere, pro-choice paladins are not using their considerable clout to persistently demand *safe*, legal abortion.

Says Meredith Vieira: "Pro-choice activists worry that clinics like Hillview will be used against them in the bitter political battle over abortion. They fear bad publicity will prompt state legislators to start regulating clinics, and that the pro-lifers will then use those regulations as a backdoor way to stop abortions. *So even though those laws could make clinics safer, [the pro-choicers] usually fight them.*" (Emphasis added.)

There is a state senator in Maryland, Mary Boergers. She is pro-choice and she is also a strong advocate of regulating abortion clinics. That position, Vieira notes, has lost her support among her pro-choice colleagues. Those colleagues, says Boergers, treat her as if she's "the enemy."

Meanwhile, a national pro-choice leader, Barbara Radford, told Meredith Vieira that regulations aren't necessary because—watch this curve—the state has enough power to discipline doctors who work at abortion clinics.

Sure, Meredith Vieira responded, "The state can investigate individual physicians. But when one doctor gets into trouble at Hillview, Lofton simply hires another one. *The state can't touch Lofton or her clinic.*"

There has to be some legislation, Senator Boergers insists, "if we really care about all the women of this state.

“When we say what we’re trying to do is guarantee safe abortions, and eliminate back-alley unsafe abortions, and yet you can demonstrate that there’s a woman who died, and another woman who’s paralyzed, then not only that argument, but all arguments from the pro-choice community can become suspect.”

And what does Barbara Radford say? “We want to make sure that women have choices when it comes to abortion services. And if you regulate it too strictly, you then deny women the access to service.”

Even if the service leads right into the grave.

Meanwhile, the Maryland legislature, in its recently passed abortion bill, gave explicit protection—not to women but to physicians who perform abortions:

“The physician is not liable for civil damages or subject to a criminal penalty for a decision to perform an abortion . . . made in good faith and in the physician’s best medical judgment in accordance with accepted standards of medical practice. ”

All kinds of “accidents” can occur when a physician performs an abortion in “good faith” and “under accepted standards of medical practice.” As Pat Groves, a nurse in Maryland, points out, this exemption means, in effect, an exemption from liability for just about any harm done during an abortion.

Meanwhile, a bill to regulate Maryland abortion clinics—supported by Mary Boergers—failed again this year. If pro-choice organizations had supported it, the bill might well have passed.

Remember the completely paralyzed Suzanne Logan? As Meredith Vieira says, it is too late for any regulations of abortion clinics that will help Suzanne. “She spends most of her days alone in the nursing home. She rarely has visitors.”

And Barbara Radford, head of the National Abortion Federation, tells the nation on *60 Minutes* that “we had hoped [this story] would not get national publicity .”

As Gandhi said: “Truth never damages a cause that is just.”

Today's Back-Alley Abortions

Please join us in our campaign to keep abortion safe and legal. Don't wait until women are dying again.

—Faye Wattleton, president of Planned Parenthood

Even in the days of legal abortion, the back-alley persists—on a commercial street, in a medical building, with a front door, and sometimes even with a state license. . . .

The stigma of abortion is still so painful that many women—even those with private gynecologists—opt for the anonymity of a clinic chosen from the phone book. They don't shop around. They want it cheap. They want it fast. And they want it over.

Embarrassed and sometimes ashamed, many women will tolerate a low standard of care without complaint. Unless severely injured, most are reluctant to file lawsuits.

—Debbie Sontag, *Miami Herald*, September 17, 1989.

As she told me recently, Debbie Sontag is “strongly pro-choice.” She is also a persistent, careful journalist. Some of her most powerful reporting has resulted in the exposure of dangerous abortion clinics so that fewer women will be the victims of today’s “back alley” abortions. *Roe v. Wade* made abortions legal, but the Supreme Court does not have the means to make them safe.

That’s the job of city and state legislatures and public-health departments. Many of them do not take that job seriously. Only 11 states, for instance, have statutory regulation of abortion clinics. There are, of course, a considerable number of responsible, well-regulated clinics. But many advocates of abortion rights avert their eyes from what goes on in the sleazy operations where women can be badly hurt, and some do die.

Moreover, the decent abortion clinics, as Debbie Sontag writes, “are loathe to report” the indecent clinics. “They fear the adverse publicity will reflect badly on all [abortion clinics] at a politically inopportune time.”

After all, she notes, there is the militant anti-abortion movement eager to spread the word about incompetent physicians at slimy clinics—and that would be bad for the cause of abortion rights.

Still, I wonder about the morality—no matter what the political context—of not blowing the whistle on places that endanger patients, and sometimes cause their deaths. That’s not morality; it’s *Realpolitik*, Henry Kissinger-style. Two years ago, Debbie Sontag wrote in the *Miami Herald* about a horrifying series of botched abortions. A 21-year-old teacher’s aide, for example, picked up the phone book, and looked under A for abortion. She was married, had two children, and she and her husband figured they couldn’t afford a third.

Three ads had the same phone number—Abortion Access Center, Abortion Clinic-Hospital Center, Abortion Information Center. Confidentiality guaranteed; cheap; safe; and in an affluent area. Bring cash. \$175. From Sontag’s *Miami Herald* story:

Dr. Robert Kast, a graduate of the University of Guadalajara School of Medicine, estimated that she was 16 weeks pregnant. He performed the abortion and sent her home to Florida City, declaring the procedure “complete and uneventful.” . . .

That night . . . she began to bleed. Heavily. By the time the ambulance came to take her to James Archer Smith Hospital in Homestead, she was unconscious.

An X-ray exposed a dead fetus, five months old.

Later, Kast would tell hospital doctors that he knew the abortion had been incomplete, that he had expected the patient to “pass” the fetus naturally. He would claim he had followed normal, accepted clinical procedures. . . .

Surgeons performed a Caesarean section. They removed a mutilated, foot-long male fetus that weighed about four-fifths of a pound.

Dr. Charles Marshall House, then the hospital’s chief of staff, told Debbie Sontag that he was “shocked and outraged” at what had happened to the patient. As for the male fetus, it looked, said Dr. House, “like the baby had been half-eaten by a dog.”

The “*baby*”? *Babies* are aborted?

Then there was one of the Dadeland Family Planning Center cases, reported by Debbie Sontag:

Ellen Lorena Williams was 38 years old, and she had a good job as a personnel manager for the Dade County School Board. Married, with two kids, she had no place in her life for another child. So when she realized she was pregnant, she called Dadeland Family Planning.

Williams was a big woman, six feet tall and nearly 300 pounds. Dr. Chatoor Bisal Singh, a graduate of the University of the West Indies medical school, could not tell exactly how pregnant she was. He sent her to get a sonogram and estimated from the results that Williams was 13 weeks along. . . .

Singh performed a suction abortion on Williams, after she signed a consent form stating she was aware that “complications from abortion are uncommon in the hands of trained medical personnel; however, they sometimes occur.”

Two days later, accompanied by her husband, Walter, a mechanic, she returned to the clinic. . . . holding her arms across her stomach and rocking back and forth, she said the pain was nearly unbearable.

Dr. Singh was called, and arrived four hours later. In an examining room, he performed a second suctioning, assisted by “Dr. Nabil Ghali, whose medical license, while active in Florida, had been revoked in Kentucky after he was convicted for having sexual intercourse with a 13-year-old girl.

“Williams was discharged with a bottle of antibiotics.” The next morning, the clinic “took a sample of Williams’ blood to a laboratory for analysis, but the lab refused to run a culture because the clinic had not protected the specimen in a sterile container. At about the same time, Williams was being rushed by ambulance to Coral Reef Hospital, where she underwent emergency surgery. The surgery was too late. Her uterus and bowel had been perforated during the first abortion and the infection was acute.

“Williams died the next morning.”

This very place, the Dadeland Family Planning Center, had a visit from Operation Rescue: 138 demonstrators were arrested for blocking the entrance to the clinic.

“It was a major media event,” wrote Debbie Sontag in the *Miami Herald*, “and pro-choice activists believed it demanded a counter-demonstration. [They Felt] they really should be there on behalf of the issue, not the individual clinic. But it made them queasy.

“Says pro-choice activist Lynn Rosenthal: ‘We’re committed to protecting access to abortion care, but to go and defend that place. . . .’

“*Still, they went.*” (Emphasis added.)

Sontag, later in her *Miami Herald* article, noted that dangerous abortion clinics “put Florida’s pro-choice advocates in a difficult ethical position.

“‘In my gut,’ says Janis Compton-Carr, full-time Florida pro-choice activist, ‘I am completely aghast at what goes on at [the Dadeland Family Planning Center]. *But I staunchly oppose anything that would correct this situation in law.*’

That is: Greater state regulation of abortion clinics. [Emphasis added.]

“Regulation has been a political battle since the day abortion was legalized. The lines are clearly drawn: The anti-abortion people want them, and the pro-choice people don’t.

“Regulations, pro-choice people say, are harassment, government interference in a private matter. In practice, they would not protect women but rather make it more difficult for them to obtain an abortion—which is their right.”

And if, without regulations, some women are placed in great danger? Well, say those pro-choicers, only a very few die.

What's the acceptable number?

During the events at the Dadeland Family Planning Center, by the way, a state official was quoted by the Associated Press as saying that veterinary clinics in Florida were under more stringent regulations than abortion centers.

Recently, I asked Debbie Sontag what reactions there had been from Florida pro-choicers to her stories about destructive abortion clinics.

"I was viciously attacked," she said. "They didn't understand where I was coming from. Also, the then executive editor of the *Miami Herald*—she had done a lot of work with women's groups—was leaned on to hold my story indefinitely."

In the two years since the stories ran, there have been no new, stricter regulations of Florida's abortion clinics. The state has closed the Dadeland Family Planning Center. But a woman wanting an abortion can still take her life in her hands when she starts looking under A in the phone book.

Nationally, according to the May 1 *Washington Post*, "roughly 8000 physicians performed most of the 1.6 million abortions in the United States last year, but their ranks are shrinking. . . . Roughly 70 per cent of these abortions are performed at 300 clinics catering to women's health needs."

As the *60 Minutes* program on the frightening abortion clinic in Maryland indicated, national abortion-rights leaders, not only those in Florida, do not make a point of fighting for stronger regulations to guarantee *safe*, legal abortions at clinics.

Bizarrely, these pro-choice leaders do not realize that politically, their cause will be strengthened if they're seen to be deeply and continually concerned with the safety of those women who choose to have an abortion.

Conversely, as more Americans come to realize that these pro-abortion-rights leaders prefer to play politics with women's lives by downplaying the need for stronger regulations, the pro-lifers will gain.

Most of the people I know are pro-choice. I'm pro-life. But I was struck by how many pro-choice foot soldiers were repelled by the anti-regulation stance of pro-choice leaders on the *60 Minutes* program about the Maryland clinic. The leaders showed themselves willing to sacrifice individual women for maximum, easy access to abortion for all. But they never tell you that in their fundraising ads and letters.

Since Abortions Are Legal, Why Can't They Be Safe?

Considering the annual number of abortions in this country (1.6 million), deaths in abortion clinics are few. But each one is, of course, traumatic, to say the least, to the families and friends of the deceased. And the number of women who suffer injuries because of mishandled abortions cannot be accurately determined because, as Debbie Sontag of the *Miami Herald* points out, “Embarrassed and sometimes ashamed, many women will tolerate a low standard of care without complaint.”

Most of the deaths and the injuries could be prevented if abortion clinics—where 70 per cent of abortions take place—were firmly and closely regulated. But abortion-rights groups often do not press for strong regulations because, they say, such regulations would make it more difficult for women to get abortions.

On the other hand, if these groups—the National Organization for Women, the National Abortion Rights Action League, the National Abortion Federation, Planned Parenthood, the ACLU—were to use their considerable clout to make “safe, legal abortions” more than a slogan, they could greatly diminish the number of women who suffer from current post-*Roe v. Wade* “back alley” abortions. And they could have protected many of those for whom any help is now too late.

Stacy Ruckman, for instance. The January 24, 1991, *Springfield News-Ledger* in Missouri reported:

“Dr. Scott Barrett Jr., abortionist at the Central Health Center for Women in Springfield, did 35-40 abortions per day for \$300 each. Barrett was able to process women so quickly in part due to his use of excessive doses of lidocaine anesthetic; a former nurse testified that two or three patients each day would go into convulsions in reaction to the high dosage.

“Stacy Ruckman did not only convulse; she died. Her parents have been awarded \$330,000 in actual damages and \$25 million in aggravated damages. . . . He is still doing abortions two days per week.”

From the December 11, 1990 New York *Daily News*:

“The family of a 13-year old Queens girl [Dawn Ravenell] who died following a legal abortion has been awarded \$1.225 million—believed the largest award ever in the state involving an abortion death due to negligence. “‘Her parents never knew about the pregnancy,’ said family attorney Thomas Principe. ‘It was a horrible situation. Here you have a frightened kid in what was really an abortion factory. She was treated like a piece on an assembly line.’ . . .

“According to statements made before the jury [nurse Robert] Augent gave Ravenell only enough anesthesia for half of the 15-minute operation. . . . Clinic records show that Ravenell awoke mid-operation and began gagging and choking on her vomit. . . .

“[Dr. Allen J.] Klein placed a plastic airway in the girl’s throat and she stabilized. Ravenell was again sedated, the abortion was completed and she was left unattended in the recovery room, where she awoke and began gagging on the unremoved airway.

“Ravenell went into cardiac collapse before a passing attendant noticed the girl’s condition and had her rushed to St. Luke’s, where she later died.”

In the January 7, 1971, New York *Post*, the Ravenell family’s lawyer, Thomas Principe said: “A 13-year old child is in no position to make such a momentous decision as to have an abortion. I’ll never forget, in cross-examining the doctor, I asked whether Dawn’s age attracted his attention and he said, ‘*Oh no, I’ve done 13-year-olds before. When they’re 10, maybe I’ll notice.*’” (Emphasis added.)

Would the abortion-rights groups—to whom parental-consent laws are anathema—make an exception for 13-year-olds? For 10-year-olds?

In its March 12, 1988, edition, the Los Angeles *Herald-Examiner* reported that three young women—18, 20, and 22—had died within 18 months at the Her Medical Clinic, which operates as a doctor’s office.

On February 22, the *Herald-Examiner* told what had happened to the three patients. One was Donna K. Heim, a preschool teacher, who was five and a half months pregnant. “Planned Parenthood had turned her away because she was too far along,” but the Her Clinic did not, and she waited there “on bus station benches in a crowded, frenetic room.”

When she was called, Donna Heim “wrote several times” on the medical forms that she had asthma. This was also noted and underlined on the medical history taken from her.

According to medical records subpoenaed by a lawyer for the family and obtained by the *Herald Examiner*, “approximately 10 minutes into the 15-minute procedure, the nurse-anesthetist had trouble getting oxygen to Heim’s lungs.

“She reported this to the doctor performing the abortion, Dr. Mahlon Cannon, but the report states that he continued the abortion procedure for five minutes, before helping the nurse, who was still trying to get Heim to breathe.

“Cannon then applied the Heimlich maneuver and performed an emergency tracheostomy, cutting a hole in Heim’s throat to get her breathing again. Still, nothing worked.”

Having suffered a cardiac arrest, Donna Heim was rushed to California Medical Center and died the following day.

According to the coroner’s office, her death was a “therapeutic accident.” It

was caused “by lack of oxygen after anesthesia, complicated by bronchial asthma and allergy.”

But the clinic knew she had asthma. Richard Heim, father of the dead young woman, has a logical question:

“The nurse told the doctor she was having problems, that her heart was stopping. Why didn’t he stop then and do something?”

The family filed a wrongful-death suit against the Her Medical Clinic. The clinic’s lawyer, Alan Freedman—according to the Los Angeles *Herald-Examiner*—said Donna Heim was to blame for failing to care for her own safety. . . . She was aware of the hazards of undergoing an abortion.”

I wonder if Donna Heim saw any of those ads by abortion-rights groups saying that now that abortion is legal, the days of the coat hangers and the back-alley doctors are gone. The ads saying now that abortions are legal, they’re safe.

With regard to protecting women who want an abortion, some pro-lifers are also culpable for putting women in danger. I mean those fake “clinics” that advertise “abortion information and services.”

The intent of these places is to persuade women *not* to have an abortion, but first they have to get women into the “clinic,” and they do that by lying about the purpose of the clinic.

In the May 6 issue of *American Medical News*, there is a report of a lawsuit brought by a woman who “went to a clinic that advertised ‘abortion information and services.’ She was shown slides of dismembered fetuses and abortions performed with crude instruments.”

The cause of action for the suit—according to a federal circuit court in Missouri—is that “there was a conspiracy to prevent her from obtaining a legal abortion.”

This is how the scam works.

“The woman said that when she first called the clinic, a staff member stated they would ‘help her all they could.’ When the woman arrived, she was asked for a urine specimen for a pregnancy test. She was then taken to a room for the slide show.

“When the woman expressed her distress, a clinic staff member told her to rely on religious faith. The staff member finally agreed to make an appointment for an abortion at a hospital.”

“When the woman went to the hospital, she discovered it was a Roman Catholic institution *and the physicians did not perform abortions*. She obtained an abortion elsewhere. [Emphasis added.]

“About a month later, the clinic staff member phoned the woman to ask when the baby was due.”

The woman’s conspiracy charge against the clinic was based on its depriving her of “the equal protection of the law through denial of her constitutional rights

of privacy, autonomy, personhood, and liberty in making a choice as to whether to continue her pregnancy.”

She is asking for actual damages of \$150,000 and punitive damages of up to \$10 million.

Her suit was dismissed below, but the case has been sent back to the lower court for further proceedings. (For those interested, it's *Lewis v. Pearson Foundation, Inc.*, 908 F. 2d 318 [C.A. 8. Mo., July 10,1990].)

Not only is a cruel deception involved in this kind of scam, but the woman can be at very serious risk. Only a small percentage of abortions are performed because the pregnancy is actually dangerous to the woman's life or puts her health in serious peril. But there are such cases, and if a woman in that condition is delayed in getting an abortion by one of these bunco setups, she could die. The fact that such fake clinics exist does not at all lessen the burden of responsibility on abortion-rights groups to insist that actual abortion clinics be carefully regulated.

In a 1989 interview with Debbie Sontag of the *Miami Herald*, Barbara Radford, head of the National Abortion Federation, said: “Let's face it. Abortion attracted undesirable operators when it was illegal. And it has not been legal that long. In some areas, there is still a feeling that providing abortions is something quasi-legal.”

Radford went on to say that the anti-abortion forces, by putting various pressures on abortion clinics, diminish the number of qualified doctors who will perform abortions because “they think it's not worth the hassle.”

According to Radford, “all of this makes it easier for places that take advantage of women to exist. And we just can't allow this. We can't allow the other side to dictate the terms of debate. We shouldn't speak in whispers and we shouldn't be cowed. If we are advocates for women, we have to protect women.”

But this year, when *60 Minutes* exposed a dreadful abortion clinic in Maryland, the very same Barbara Radford told reporter Meredith Vieira: “We had hoped it wouldn't get national publicity because of the political nature of all of this.” And Radford opposed strict regulations of abortion clinics.

Creating a Master Race

As we [the Committee To Defend Reproductive Freedom Rights] sat on folding chairs in the Women's Building, I talked about the history of the eugenics movement, especially in terms of disabled people, and how it had reached its terrible fulfillment in Nazi Germany—first in the forcible sterilization of disabled people and then in genocide, which began not in the concentration camps but in the hospitals and mental institutions in Germany.

—Anne Finger, “A Lot to Learn,” *Disability Rag*, March/April 1990

The Germans did not have the benefit of our prenatal genetic screening—which is rapidly becoming even more sophisticated. If they had been able to search out genetic defects in the fetus, think of the money and the man-hours they would have saved by simply aborting what the gentle German animal behaviorist Konrad Lorenz used to call “deleterious mutations.”

The Nazis gave eugenics a bad name. But there are still a lot of people in this country who would like to purify the stock. Some are racists; others are concerned with costs. It costs money, they say, to care for certain people born with certain genetic defects, and since their “quality of life” isn’t going to be so hot anyway, why not give the tax-payers a break and kill the defective in the womb.

Moreover, it’s getting harder to legally discriminate against the disabled once they’re here—particularly as a result of last year’s Americans with Disabilities Act. So genetic screening makes all the more sense. Kill them before they start moving amongst us.

Then there are those people, and they are legion, who are not concerned with any of these social questions, but simply want a perfect baby.

So, quiet as the name is kept, eugenics is becoming as American as ballpark hot dogs.

Indeed, for the first time, so far as I can find out, an official approval of eugenics has been written into a state law.

It is not illegal to be tested—through amniocentesis and other ways of screening—in order to find out if the fetus has a genetic defect. If it has, you can destroy it through abortion. But to enact a law that specifically endorses the killing of the fetus if he or she has *any genetic defect whatsoever*—no matter how slight—is a great step ahead toward creating near-perfect beings. What

some used to call a master race.

The state is Maryland, whose legislature on February 18 passed an abortion bill. Generally, the press described it as a “moderate” statute. It assured the women of Maryland that if the Supreme Court ever overturns *Roe v. Wade*, the very same protections will continue to exist under Maryland law.

As a consolation prize to the pro-lifers, the law has a parental consent clause, but it’s a fake. The decision whether to inform the parents of an “unmarried minor” is left to—guess who?—the doctor about to perform the abortion. If he or she believes the minor is “mature and capable of informed consent” or if the doctor believes that telling the parents would not be in the minor’s best interest, the parents will not hear a word.

Then comes the endorsement of eugenics. In the state of Maryland, a fetus may now be aborted “at any time during the woman’s pregnancy” if THE FETUS IS AFFECTED BY GENETIC DEFECT OR SERIOUS DEFORMITY OR ABNORMALITY. That means, of course, a *viable* fetus can be done away with.

You will note that with regard to “deformity or abnormality,” there’s a qualifier. Those conditions have to be “serious,” whatever that may mean, if the fetus is to be destroyed. But there is no qualifier to “genetic defect.” As one legal expert in this field told me, “if ‘myopia’ is discovered, you could—by the language of this section—abort a nearsighted fetus in the seventh month, or later.” It’s hardly likely to happen, but it would be legal if it did.

And if you find out there is a defect that goes with sickle cell anemia, cystic fibrosis, or many more conditions that can now be detected, then throw the fetus back into the sea.

In time, nearly all genes will be mapped, and there will be a perfect race.

I found out that in the Maryland general assembly (the lower house) one delegate, Donald Elliot, had offered an amendment which would have inserted “serious” before “genetic defect.” There was little floor debate, and the amendment was defeated 75 to 55.

Elliot told me that a fellow delegate, a pro-choicer, had leaned toward him during the debate and said softly, “That’s a good amendment.”

“Then you’ll vote for it?” Elliot asked.

“No, I have no choice,” said the pro-choicer. “The senate leader says that if this bill comes back with any amendments, he’ll stick it in a drawer.”

And that’s how eugenics came gamboling into Maryland.

There was another amendment:

“A person may not intentionally perform or attempt to perform an abortion with knowledge that the pregnant woman is seeking the abortion solely because the sex of the unborn child is not the gender desired by the pregnant woman.” That went down 74 to 58.

What the hell, coming up with the wrong sex can be interpreted as a genetic defect, right? And guess which gender is more often killed off this way? Females. Some choice.

Anyway, the legal director of the Illinois American Civil Liberties Union has told me that a woman can have an abortion for any reason she wants, including gender selection. Hair color too? Why not? It's the right to choose.

As for the killing of viable fetuses because they have one of dozens of discernible genetic defects, it should be remembered that before *Roe v. Wade* a post-viability abortion was known as infanticide.

I'd read about the Maryland abortion law, but none of the papers mentioned its salute to the legal return of open-ended eugenics.

But in March, I got a letter from Richard Stith, a law professor at Valparaiso University in Indiana. He enclosed the cheery new statute, and noted:

"Those opposed to people with disabilities just won more in Maryland than ever before in any state or nation of the modern world. An unborn child *able to survive on his or her own* can be killed simply for having some minor 'defect.'

"The law . . . unmasks the ableists, reveals their elitist arrogance toward anyone less than perfect. It finally makes clear the nature of the ideology that has been pushing for 'autonomy' rights to withhold food and water from 'defective' newborns and unconscious adults."

Richard Stith fears that the "genetic defect" law will spread throughout the country. If it were to come before the New York State legislature, it would surely pass the assembly—shepherded, I expect, by Richard Gottfried. The Senate would probably kill it, but you can't be too sure. After all, the New York Senate finally approved the health proxy act, which is a kissing cousin to euthanasia. Elsewhere in the country, Maryland's doorway to large-scale eugenics should do quite well in some states.

The one surprise I've had in reaction to the Maryland bill has been the silence, so far as I know, of the disability rights organizations. For a long time, in conversations with disability activists and at meetings of their organizations, I've heard apprehensive talk that just such a bill might someday come into being.

Well, here *it* is, and where are *they*? It is true that disability rights groups are ambivalent about abortion and anything connected with it. Some of the members are pro-choice; others have no firm opinion but do not want to be identified with so controversial a movement. They figure they have enough problems of their own without the bad press that pro-lifers get. And when disability rights people lobby legislators, they also don't want their priorities blurred with those of pro-lifers.

Some of the key disability groups, however, have been willing to oppose euthanasia (as in the Nancy Cruzan case) and to support the rights of Baby Does—severely handicapped infants whose parents want to let them slide into

eternity. The disabled know that as it becomes easier for society to get rid of expensively imperfect people, they themselves may eventually not be safe from lethal mercy.

One disability rights activist is aware of the connection between the return of eugenics and certain dimensions of abortion advocacy. Anne Finger is pro-choice, a feminist, a writer (currently teaching creative writing at Wayne State University), and is herself disabled.

In the *Disability Rag* (March/ April 1990), she tells of having joined an abortion rights group and of offering to speak at a meeting about disability and reproductive rights:

“When I started talking about how the reproductive rights movement was sometimes guilty of exploiting fears about disability when it argued for abortion because of fetal defect, things got really strained. I expected lip service, condescension, liberalism—but certainly not hostility.”

Also at the same meeting was a Harvard biology professor, Ruth Hubbard, since retired. She was not hostile to Anne Finger: “My problems with prenatal screening stem mostly from my concern about how it’s creating eugenic thinking.

“We act as if we can look at a gene and say, ‘Ah-ha, this gene causes this . . . disability,’ when in fact the interactions between the gene and the environment are enormously complex. It moves our focus from the environmental causes of disabilities—which are terrifying and increasing daily—to individual genetic ones.”

The pro-choice forces, however, are so intent on removing all obstacles to abortion—for instance, Congressman Don Edwards’s draconian Freedom of Choice Act of 1991, supported mindlessly and mercilessly by the ACLU—that eugenics is no specter to them.

But Anne Finger remembers the stunning initial triumph of eugenics as it killed the disabled in the hospitals and mental institutions of Germany—before the Nazis came for the Jews and the homosexuals and the Poles and the Russians and the gypsies.

Anne Finger is still pro-choice; but unlike most people in the movement (very much including the ACLU) she also knows what certain choices can lead to.

The Freedom of Terminal Choice Act

Rep. Don Edwards (D-Calif.) can justifiably be called the congressman from the Constitution. No one in Congress equals his passionate and skillful determination to protect the Bill of Rights and the 14th Amendment. Way back, he was one of only a dozen or so representatives supporting the abolition of the House Committee on Un-American Activities.

And for years, as chairman of the house Judiciary Committee's panel on civil and constitutional rights, with oversight over the FBI, Edwards has kept that impatient agency reluctantly aware of such necessary annoyances as the Fourth and First amendments.

When it comes to abortion rights, however, Edwards has introduced a bill—the Freedom of Choice Act—that does what Sir Thomas More warned against in “A Man for All Seasons”: “What would you do? Cut a great road through the law to get after the devil?”

To Edwards, the Devil is the pro-life movement, and his bill—H.R. 25 with Senate duplicate S. 25—would cut down practically all the laws in the individual states that restrict abortions.

The American Civil Liberties Union, which enthusiastically supports the Freedom of Choice Act, notes with anticipation that should it become law, “among the restrictions that would be prohibited . . . are spousal consent requirements, waiting periods, parental notification and consent, and requirements that all abortions be performed in hospitals.”

The ACLU neglected to cite another restriction that would be abolished in every state—a conscience exception for those doctors and nurses who do not want to be forced to participate in abortions. Through the years, I've talked to nurses throughout the country—not all of them pro-life—who are sickened at having to be involved in second-trimester abortions in which the live fetus is dismembered (dilation and evacuation).

Some 44 states have conscience clauses that allow nurses and doctors to *choose*—a one-sided word in Edwards's bill—not to take part in other people's lethal choices.

In October 1990, as this bill was taking shape in Edwards's subcommittee, Rep. F. James Sensenbrenner (R-Wis.) offered an amendment:

“Nothing in this Act precludes a state from enforcing a law which allows a health care provider to refuse to perform or assist in the performance of an abortion because it offends the provider's moral conscience or religious beliefs.”

With Edwards in the lead, the conscience amendment was voted down, 5-3, on party lines. One of those voting thumbs down was Rep. Pat Schroeder (D-Colo.). She is usually acutely sensitive to the claims of individual conscience, but obviously the preservation of abortion rights is so overwhelming a priority that the right of individual conscience simply cannot compete, even for such professional civil libertarians as the ACLU's lobbyists.

Rep. Barney Frank (D-Mass.) is an exception. Frank, a fervent supporter of abortion rights, tells me that he feels strongly there ought to be a conscience clause in the Freedom of Choice Act.

When Edwards first introduced the measure, he told me he wanted a "clean bill—no exceptions." Well there is one exception. His bill says a state may not restrict abortion in any way "before fetal viability." But then it says, a state cannot prevent an abortion "at anytime, if such termination is necessary to protect the life or the health of the woman." (George Orwell would have savored "termination.")

Since the *Doe v. Bolton* Supreme Court decision in 1973, "health" means emotional as well as physical health—"all factors relevant to the well-being of the patient." So "viability" is not an exception after all.

Senate Majority Leader George Mitchell (D-Maine), who is pro-choice, thinks that the Edwards bill would set a "very dangerous precedent." A national abortion policy, he says, should only be established by a constitutional amendment. Otherwise, another Congress down the line could repeal this sweeping unilateral choice. Mitchell asks whether so fundamental a right ought to be left to majoritarian vote.

But Edwards is not going to be deterred by constitutional niceties. I hope that hearings on the bill will include nurses who will bring photographs. I also hope C-Span will be there.

The Perilous Journey of *Roe v. Wade*

Jane Roe. Despite the use of the pseudonym, it is not suggested that Roe is a fictitious person. For purposes of her case, we accept as true her existence, her pregnant state as of the time of the inception of her suit in March 1970. . . . She, as a pregnant single woman, thwarted by the State's abortion laws, had standing to challenge them.

—First draft of Justice Harry Blackmun's eventual majority opinion in *Roe v. Wade*, 1973

We . . . conclude that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation.

—Final majority opinion by Harry Blackmun, *Roe v. Wade*, 1973

A chill wind blows as [the majority of this Court] casts into darkness the hopes and visions of every woman in this country who had come to believe that the Constitution guaranteed her the right to exercise some control over her unique ability to bear children.

—Harry Blackmun, dissenting, *Webster v. Reproductive Health Services*, 1989

*Has the Supreme Court overruled *Roe v. Wade* . . . holding that a woman's right to choose abortion is a fundamental right protected by the United States Constitution?*

—Petition to the Supreme Court by Planned Parenthood, represented by the American Civil Liberties Union on November 7, 1991, in *Planned Parenthood v. Casey* (oral arguments in the case on April 22 of this year)

Twenty years ago, during arguments before the Supreme Court in *Roe v. Wade*, Justice Byron White asked a cactus-like question of Sarah Weddington, the lawyer from Austin, Texas, who was representing Jane Roe in her attempt to strike down the punitive abortion laws of Texas. Any way that Sarah Weddington answered that question could get her and her case in trouble with

one or more of the justices who were sitting above her.

White asked how far Weddington wanted the right of abortion to go: “Will that take you right up to the time of birth?”

She gave an honest answer rather than blowing smoke: “It is our position that the freedom involved is that of the woman to determine whether or not to continue a pregnancy. Obviously, I have a much more difficult time saying that the state has no interest in late pregnancy.”

White: “Why? Why is that?”

Weddington: “I think it’s more the emotional response to a late pregnancy, rather than it is any constitutional. . . .”

White: “Emotional response by whom?”

Weddington: “I guess by persons considering the issue outside the legal context. The Constitution, as I see it, gives protection to people *after* birth.”

Weddington was arguing that there are no rights of the unborn specifically enumerated in the Constitution before or after the Bill of Rights. Therefore, if the Court were to decide that it is a woman’s constitutional right to choose whether to carry a fetus to term, there should be no legal—no constitutional—interference with that right. But it’s understandable, she implied, that a lot of people might well be emotionally disturbed by the idea of a late abortion. That consideration, however, should not be part of a “legal context.”

She was arguing for abortion on demand.

Weddington, by the way, did not base her argument before the Court on a constitutional right to privacy. She relied on the Fourteenth Amendment’s right of “liberty.” (“Nor shall any State deprive any person of life, liberty, or property without due process of law.”)

She said that “liberty to these women would mean liberty from being forced to continue the unwanted pregnancy.” Under the due process and equal protection clauses of the Fourteenth Amendment, she added, women should not be compelled to bear the fetus to term. “One of the purposes of the Constitution was to guarantee to the individual the right to determine the course of their own lives.”

What happened then? What happened after the justices went into the conference room—in which no one else is allowed—and delivered their initial opinions and tentative votes?

Usually, there’s no way of knowing, the Court being the most secretive governmental institution in the country. Occasionally, however, one of the few justices who gives interviews may provide some information or limited access to his or her papers.

One law professor, however, has done a lot better than that, and his illuminations will be quoted by writers on the making of constitutional law as long as there is a Supreme Court. Bernard Schwartz, a professor of law at New York

University, has published a series of books that takes you inside the Court's conference room and also reveals the exchanges of initial drafts of opinions among the justices—along with memoranda, notes, and interviews with some justices and former law clerks.

In *The Unpublished Opinions of the Burger Court* (Oxford University Press, 1988), Professor Schwartz told how *Roe v. Wade* was born. It was a long, troubled pregnancy.

At first, justice Blackmun was not sufficiently convinced that abortion laws should be struck down on equal protection or privacy grounds. His original draft, as Schwartz notes, declared the Texas statute before the court to be unconstitutional “on the ground of vagueness and not because it restricted a woman's right to have an abortion.”

During the months of exchanges of views—including drafts of opinions by some of the justices—William Brennan and William O. Douglas were the strongest voices for a woman's fundamental right to decide to have an abortion. And for the need to strike down the Texas law to achieve that result.

Brennan was and is a devout Catholic who attends Mass regularly. But he never let his own religious beliefs affect his constitutional judgments. Some years ago, I was in Washington covering an annual meeting of the National Conference of Catholic Bishops. A couple of days before, Brennan had delivered one of his customary majority decisions decisively separating church and state with regard to public schools. There was to be no connection of any religious institution with any public school.

As I watched, a series of bishops and archbishops denounced Justice Brennan in such scalding terms that it was as if he were the Antichrist. Around that time, one Southern cleric—a Baptist, as I remember—used to pray fervently, publicly, and regularly for Brennan's imminent death.

It was not only that Brennan's religion did not in any way affect his views on the constitutional right of women to choose abortion. He was also a feminist—the most passionate in the history of the Court. He used to interchange the personal pronouns in his opinions—referring to the principal in a case interchangeably as “she” and “he.” I asked him why, and he said, “Why should we males be the only illustrious participants in whatever events we've been talking about?”

Also, more than anyone else on the Court, he tried to awaken a majority of his colleagues on a given case to the realization that women were *not* getting equal protection under the Fourteenth Amendment—and sometimes he succeeded. In a landmark opinion in a 1973 gender discrimination case (*Frontiero v. Richardson*), Brennan wrote scornfully of this country's tradition of “roman-

tic paternalism,” which “in effect, put women not on a pedestal, but in a cage.”

So, on constitutional and feminist grounds, Brennan wanted the Court to liberate, as he saw it, Jane Roe. So did William O. Douglas. Unlike Blackmun, who at first shied away from the right-of-privacy approach, Douglas—with his customary force and clarity—embraced it. He did not, however, go all the way with Sarah Weddington. The right to abortion should not be unqualified. Not after the “early stages” of pregnancy. At some point, “the liberty of the mother,” although grounded in the Constitution, can be regulated by the state, said Douglas. During the early rounds of debate on *Roe v. Wade* inside the Court, Blackmun spent a lot of time in the Court library. He was a slow worker to begin with, and he knew that this would be not only his first major case but also very controversial. I doubt if he knew how controversial it would be. He’s been getting death threats ever since.

Douglas, meanwhile, was writing drafts and memos, emphasizing that this right of a woman to abort should come out as a *fundamental* constitutional right. Any right designated as fundamental by the Supreme Court—the right to vote, to interstate travel, to marry, to be free of racial discrimination—cannot be narrowed by government *unless* an agency of the state can show “a compelling state interest” to regulate that right.

When government comes before the Court claiming that a fundamental right has to be diminished in some respect, that claim by government is looked at by the Court with “strict judicial scrutiny”—the highest standard by which the Court classifies the cases before it. Furthermore, as Douglas pointed out, even if the state does show a “compelling interest” in interfering with a fundamental right, any regulations should be narrowly and precisely drawn. Otherwise, he told his colleagues, “the police-power would become the great leveler of constitutional rights and liberties.”

In a subsequent letter to Douglas, while the deliberations were going on, William Brennan spoke of “three groups of fundamental freedoms that ‘liberty’ in the Fourteenth Amendment encompasses:

“*First*, freedom from bodily restraint or inspection, freedom to do with one’s body as one likes, and freedom to care for one’s health and person; *second*, freedom of choice in the basic decisions of life, such as marriage, divorce, procreation, contraception, and the education and upbringing of children; and “*third*, autonomous control over the development and expression of one’s intellect and personality.”

The right to abort a pregnancy, Brennan went on, “fits directly within each of the categories of fundamental freedoms I’ve identified and, therefore, should be held to involve a basic individual right.” Like Douglas, Brennan advocated no state interference in “the early part of the term.” And the state, he said, has

no business judging the reasons for an abortion. “The decision is that of the woman and her alone.”

But even Jane Roe’s most outspoken defenders on the Court did concede that the state had some kind of interest in the life of the fetus after the “early part of the term.” For a time, however, that state interest largely receded. But eventually, a very “chill wind” came down on what Jane Roe had wrought, as the membership of the Court fundamentally changed. (To be continued.)

Eight Men and One Woman in Black Robes

My greatest fear is that the Court will never provide a single dramatic ruling while the country becomes more and more accustomed to more and more women actually losing access to abortion.

—Duke University law professor Walter Dellinger

When lawyers prepare for oral arguments before the Supreme Court, they act much like handicappers before going to the track. You can pretty well figure that certain justices are on your side—but you could be wrong. And others, also based on their track records, have probably already decided against you, and will relish giving you grief. But almost always, there are some who, in the past, have taken some positions that you may be able to build on to your advantage.

So, in your briefs before you get to the Court—and in your oral argument—you will try to focus on the possibly friendly justices. You may quote from some of their previous opinions or dissents to show how you treasure their every judicial word.

Preparing for *Planned Parenthood v. Casey*, to be heard before the Court on April 22, Ernest Preate, attorney general of Pennsylvania—arguing for the constitutionality of a broad range of that state’s restrictions on abortion—must have been quite optimistic.

But Kathryn Kolbert, his opponent, saw only two sure allies on the high bench. Still, there could be others who might at least pay attention to what she had to say. Kolbert, a very knowledgeable and determined staff attorney with the ACLU, was representing Planned Parenthood of Southeastern Pennsylvania and four abortion clinics.

This is what both Kolbert and Preate faced as they entered the small courtroom and looked up at the justices.

The two original dissenters in the 1973 *Roe v. Wade* decision—William Rehnquist and Byron White—are still on the Court. Through the years, there has been no evidence that Rehnquist, now the chief justice, has any pronounced religious or moral objections to abortion. Instead, as *Los Angeles Times* Supreme Court reporter David Savage says in his valuable forthcoming book, *Turning Right: The Making of the Rehnquist Supreme Court* (Wiley): “In (Rehnquist’s) view, the Constitution neither gave women a right to choose abortion nor guaranteed the fetus a right to life. Because neither was decided by the

Constitution, the states and their elected officials could decide for themselves.”

As for Byron White, his objection to making abortion a constitutional right seemed based in part on federalism, but unlike Rehnquist, he appeared to have strong moral objections to *Roe v. Wade*. In his original dissent, he accused the majority of exercising “raw judicial power,” but he also was much troubled that the Court had allowed abortion to “satisfy the convenience, whim, or caprice of the putative mother.”

Kathryn Kolbert knew that neither Rehnquist nor White had changed their minds since 1973. A newer justice, Antonin Scalia, was, if possible, even more determined to send the abortion question back to the individual states. He has no patience with what he sees as the Court’s slowness in this matter. He scornfully mocks those of his colleagues who are dismantling the fundamental constitutional right to abortion only “doorjamb by doorjamb.” Knock the whole damn house down, says Scalia.

Anthony Kennedy had an anti-abortion record when he was a practicing attorney, and I was surprised he was able to tap-dance away from it during his confirmation hearings. Before he became a judge on the Ninth Circuit Court of Appeals, Kennedy advised pro-life California legislators on the drafting of anti-abortion bills. He would not weep if *Roe v. Wade* were struck down. He would be among the wreckers.

In researching an article on David Souter’s nomination for the *Voice*, the only—very slight—indication I found as to his abortion views was the fact that he had been on the board of a hospital in New Hampshire which, during his tenure, had started to do abortions. There had been no objection from Souter.

On the other hand, a Republican congressman, who knows his way around the White House, swore to me last year that Souter was a thoroughly “dependable” anti-*Roe* vote. I asked if this was known before Souter was nominated. “Yes,” said my source. We shall see.

As for Clarence Thomas, a close friend of his told me after Thomas had been confirmed that he had no doubt Thomas would join Scalia—if the right case came along—to obliterate *Roe v. Wade*.

Left on the Court are the only two true believers in a woman’s fundamental right to choose an abortion. One, of course, is Harry Blackmun, who wrote the original majority opinion. The other is John Paul Stevens.

Sandra Day O’Connor is in neither camp. She has taken a position that requires turning down any regulation that would place an “undue burden” on a woman’s right to an abortion. But she has also approved of various regulations restricting abortion.

In her 1986 dissent in *Richard Thornburgh v. American College of Obstetricians and Gynecologists*, Justice O’Connor explained what she means by “undue burden”:

“An undue burden will generally be found in situations involving absolute obstacles or severe limitations on the abortion decision—not wherever a state regulation may inhibit abortions to some degree.” For instance, she has said an “undue burden” would be a law that criminalizes all abortions except those to save the life of the mother, or that gives a husband a veto power over a woman’s ability to have an abortion.

To many pro-choicers, some of the regulations O’Connor has voted to uphold were actually severe limitations on a woman’s right to abortion. But in this, as in other areas of constitutional law—church and state, for instance—O’Connor goes her own way and sometimes becomes the deciding vote on a case.

I suggested to Kathryn Kolbert—before she went to Washington to argue before the Court—that although the votes to override *Roe v. Wade* appeared to be there, it was not likely that in this case, *Planned Parenthood v. Casey*, the Court would explicitly strike down *Roe v. Wade*. The impatient Scalia aside, various decisions in recent years had so weakened *Roe* that it might not be necessary to officially finish the job.

A fundamental constitutional right to an abortion, Kolbert said, can’t remain fundamental—even if it’s not explicitly overturned—once the Court stops looking at proposed state regulations of it under a “strict scrutiny” test. If any state tries to restrict a fundamental right, it has to—under “strict scrutiny”—convince the Court that it has a compelling interest in doing so. And if, under this tough test, the Court agrees, such regulations have to be narrowly and precisely drawn.

Since Justice O’Connor applies “strict scrutiny” only to those regulations that place an “undue burden” on abortion, one of the questions in this current case is whether she will regard any of the Pennsylvania restrictions as undue burdens. And if she does, can she bring a majority of the Court with her to keep enough of the “strict scrutiny” test to maintain abortion as a fundamental constitutional right?

That is what *Planned Parenthood v. Casey* comes to. If the majority of the Pennsylvania regulations are upheld, *Roe v. Wade*, even if it’s left alive, will slide downward until all that is required for a state to regulate abortion is the lowest standard of judicial scrutiny—the “rational basis test.”

Under that test, all a state has to do is show that it has a reason—a rational basis—to do what it wants to. Appellate courts do not often second-guess a state if that is the standard of scrutiny. Already, at least Rehnquist and Scalia on the Court have said that rules on abortion should be judged only on a rational basis standard.

The *Planned Parenthood* case, which could greatly eviscerate *Roe v. Wade*, comes from the Third Circuit Court of Appeals. That court has held—based in part on Justice O’Connor’s “undue burden” standard—that restrictions that do not *prohibit* abortions, either in their effect or explicitly, must now be judged on a “rational basis” standard. (Emphasis added.)

If the Supreme Court agrees, *Roe v. Wade* may still be breathing, but only barely. From then on, as Americans United for Life—a pro-life group—anticipates: “statutes pertaining to informed consent, waiting periods, reporting requirements, testing for fetal viability are all likely to be upheld” by future courts, following the Supreme Court.

Here are the four requirements of the Pennsylvania Abortion Control Act that the Supreme Court will be judging:

Informed Consent: “Prior to an abortion, the performing or referring physician must provide information regarding the nature of the abortion procedure, the alternatives to the procedure, the gestational age of the unborn child, and the medical risks of carrying the child to term. In addition, the physician or a counselor must inform the woman of the availability of medical assistance benefits for prenatal care, childbirth, and neonatal care. . . .”

Waiting Period: “A 24-hour period between receipt of the informed-consent disclosures and the performance of the abortion is required.”

Informed Parental Consent: “The informed consent of one parent must be obtained prior to the performance of an abortion on an unemancipated minor. A minor who does not wish to obtain parental consent may use a judicial bypass procedure. . . .”

Confidential Data Reporting: “An abortion provider must provide to the department of health a report for each abortion performed. The reports are not publicly available and are subject to safeguards to protect against disclosure.

A fifth requirement was struck down by the Third Circuit Court of Appeals, but is on appeal by Pennsylvania before the Supreme Court. It would require that a woman—before an abortion was performed—sign a statement that she had told her husband what she was going to do. The requirement is waived if the husband is not the father of the child, cannot be found, or if the pregnancy was the result of a spousal sexual assault that had been reported to law enforcement. The woman’s statement is also not required if she believes that telling her husband will result in his beating her up.

If the worst fears of the pro-choicers are realized and the Court upholds all or most of the Pennsylvania restrictions, the next step is Congress and the Freedom of Choice Act, which aims at saving *Roe v. Wade*—not as a constitutional right but as a federal statutory right, with the power to prevent the individual states from interfering with that right. Stay tuned.

Pro-Choice Bigots

Not too long ago, he was a pro-lifer. He wrote and spoke about the right to life and attacked advocates of abortion rights. “There are those who argue that the right to privacy is of a higher order than the right to life,” he would say. “That was the premise to slavery. You could not protest the existence or treatment of slaves on the plantation, because that was private and therefore outside of your right to be concerned.” He told the story of how he himself had almost been aborted. A physician had advised his mother to let him go, but she wouldn’t. Don’t let the pro-choicers convince you that a fetus isn’t a human being, he warned: “That’s how the whites dehumanized us, by calling us niggers. The first step was to distort the image of us as human beings in order to justify that which they wanted to do—and not even feel like they’d done anything wrong.”

But as Jesse Jackson decided to run for president in 1984, his fiery pro-life rhetoric suddenly subsided. If being black was a political obstacle, being black and pro-life would raise the odds much too high. Jackson understood that it is hard to be a pro-lifer if you want the support of the left—or just have friends on the left. The lockstep liberal orthodoxy on abortion is pro-choice, as Bill Clinton’s election showed and his presidency will reinforce. Dissenters are not tolerated.

Nearly ten years ago I declared myself a pro-lifer. A Jewish, atheist, civil libertarian, left-wing pro-lifer. Immediately, three women editors at *The Village Voice*, my New York base, stopped speaking to me. Not long after, I was invited to speak on this startling heresy at Nazareth College in Rochester (long since a secular institution). Two weeks before the lecture, it was canceled. The women on the lecture committee, I was told by the embarrassed professor who had asked me to come, had decided that there was a limit to the kind of speech the students could safely hear, and I was outside that limit. I was told, however, that I could come the next year to give a different talk. Even the women would very much like me to speak about one of my specialties, censorship in America. I went and was delighted to talk about censorship at Nazareth.

At the *Voice*, some of my colleagues in the editorial department wondered, I was told, when I had converted to Catholicism—the only explanation they could think of for my apostasy. (Once I received a note from someone deep in the ranks of the classified department. She too was pro-life, but would I please keep her secret? Life would be unbearable if anyone knew.)

To others, I was a novelty. Interviews were arranged on National Public Radio and various television programs, and I spoke at one of Fred Friendly’s

constitutional confrontations on PBS. Afterward, men, women, and teenagers wrote from all over the country that they had thought themselves to be solitary pro-lifers in the office, at school, even at home. They were surprised to find that there was someone else who was against capital punishment, against Reagan and Bush, and dismayed at the annual killing of 1.6 million developing human beings. They felt, they told me, that it was absurd to talk blithely of disposing of potential life. These were lives—lives with potential to someday do *New York Times* crossword puzzles and dig Charlie Parker. That is, if they weren't thrown out with the garbage.

I felt less alone myself. In time, I found other heretics. For instance, the bold, witty, crisply intelligent members of Feminists for Life of America. There are some in every state, and chapters in thirty-five. Many of them came out of the civil rights and anti-war movements, and now they also focus on blocking attempts to enact death penalty laws. They have succeeded in Minnesota. You won't see much about Feminists for Life in the press. When reporters look for pro-lifers to interview, they tend to go after pinched elderly men who look like Jesse Helms and women who wear crucifixes.

On the other hand, not all stereotypes are without actual models. As an exotic pro-lifer, I was invited to address an annual Right to Life convention in Columbus, Ohio. The event was held in a large field. A rickety platform faced the predominantly Christian crowd.

I told them that as pro-lifers, they ought to oppose capital punishment and the life-diminishing poverty associated with the policies of their Republican president. Ronald Reagan, I emphasized, had just cut the budget for the WIC program (federally funded Special Supplemental Food Program for Women, Infants, and Children). He and those who support him, I said, give credence to Massachusetts Representative Barney Frank's line: "Those who oppose abortion are pro-life only up to the moment of birth."

From the back of the crowd, and then moving forward, there were growls, shouts, and table-thumping. Suddenly, a number of people began rushing toward the platform. I said to the man sitting next to me, a leader of the flock, that I had not quite decided that this cause was worth dying for.

As it happened, the souls on fire only wanted to say that I was in grievous error about these Christian presidents because I had not yet found God. Indeed, I often get letters from religious pro-lifers telling me that it is impossible for me to be simultaneously an atheist and a pro-lifer. Some of the pro-abortion-rights leaders whom I have debated are certain of the same correlation. No serious atheist, no Jewish atheist, no left-wing atheist could want to—as my

fiercely pro-choice wife puts it—enslave women.

Yet being without theology isn't the slightest hindrance to being pro-life. As any obstetrics manual—*Williams Obstetrics*, for example—points out, there are two patients involved, and the one not yet born “should be given the same meticulous care by the physician that we long have given the pregnant woman.” Nor, biologically, does it make any sense to draw life-or-death lines at viability. Once implantation takes place, this being has all the genetic information within that makes each human being unique. And he or she embodies continually developing human life from that point on. It misses a crucial point to say that the extermination can take place because the brain has not yet functioned or because that thing is not yet a “person.” Whether the life is cut off in the fourth week or the fourteenth, the victim is one of our species, and has been from the start.

Yet rational arguments like these are met with undiluted hostility by otherwise clear-thinking liberals. Mary Meehan, a veteran of the anti-war movement, tried to pierce this pall of left orthodoxy in a 1980 article in *The Progressive*:

Some of us who went through the anti-war struggles of the 1960s and 1970s are now active in the right-to-life movement. We do not enjoy opposing our old friends on the abortion issue, but we feel that we have no choice. We are moved by what pro-life feminists call the “consistency thing”—the belief that respect for human life demands opposition to abortion, capital punishment, euthanasia, and war. . . . It is out of character for the left to neglect the weak and helpless. The traditional mark of the left has been its protection of the underdog, the weak, and the poor. . . . The unborn child is the most helpless form of humanity, even more in need of protection than the poor tenant farmer or the mental patient.

Meehan's article provoked an extraordinary amount of mail. A few writers praised *The Progressive* for having enough respect for its readers to expose them to a perspective opposite to the magazine's. But the great percentage of letter writers were furious, indignant that a “left” magazine should print such vicious right-wing propaganda.

Because defending the killing of the fetus is inconsistent with the liberal/left world view in other matters, the abortion rights orthodoxy has relied on extraordinary hypothetical arguments to justify its position in the twenty years since the *Roe* decision. Take two examples. In 1971, when abortion was legalized in New York state, an editorial on WCBS radio in New York attempted to define abortion as an act of compassion: “It is one sensible method of dealing with such problems as overpopulation, illegitimacy, and possible birth defects,”

the announcer said. “It is one way of fighting the rising welfare rolls and the increasing number of child abuse cases.”

In 1992 the defense has changed. No longer a means of compassion, abortion is now viewed as a form of preemptive law enforcement. As Nicholas von Hoffman writes in the *New York Observer*:

“Free, cheap abortion is a policy of social defense. To save ourselves from being murdered in our beds and raped on the streets, we should do everything possible to encourage pregnant women who don’t want the baby and will not take care of it to get rid of the thing before it turns into a monster. . . .

“At their demonstrations, the anti-abortionists parade around with pictures of dead and dismembered fetuses. The pro-abortionists should meet these displays with some of their own: pictures of the victims of the unaborteds—murder victims, rape victims, mutilation victims—pictures to remind us that the fight for abortion is but part of the larger struggle for safe homes and safe streets.”

As a sometime admirer of von Hoffman, I take this to be—maybe—his assuming the role of Jonathan Swift in these hard times, but it doesn’t matter particularly whether he’s serious or not. Those who see abortion as a cost-effective, even humane, way to thin the ranks of the lower orders are not few in number.

Pro-choicers clearly are only interested in their version of the choice in this matter. But why are the liberals among them so immovably illiberal only when it comes to abortion? The male pro-choicers, by and large, consider this to be entirely an issue for women to decide. And the only women they know are pro-choice. If a man has any doubts or subversive ambivalences, he keeps them to himself because should he speak of them, he will be banished from the company of all the progressive women he knows—and any whom he might hope to know.

Pro-choice women are so unyielding because they profoundly believe that without the power to abort at will, they will be enslaved. Once an abortion is wanted, the fetus, as one woman told me, is—to some women—“the enemy within.” In the fight not to be enslaved, liberalism is an abstraction.

Accordingly, I am no longer surprised to find myself considered an external enemy. For years, American Civil Liberties Union affiliates around the country invited me to speak at their fund-raising Bill of Rights dinners. But once I declared myself a pro-lifer, all such invitations stopped. They know I agree with them on most ACLU policies, but that no longer matters. I am now no better than Jesse Helms. Free speech, after all, has its limits.

This disdain on the left for anything or anyone pro-life has clearly taken a toll on the political process. Liberal/left politicians who remain true to their philosophy and oppose abortion are virtually impossible to find. Like Jackson, most simply cave in to abortion rights pressure, fearing that no matter how left-

leaning they are on other issues, if they come out against abortion they will be branded as right-wing fanatics. Governor Robert Casey of Pennsylvania, a liberal pro-life Democrat, was forbidden from speaking at this year's Democratic convention. And when *The Village Voice* later offered him a forum in New York to talk and answer questions about whether it is possible to be both liberal and pro-life, he (and I, the putative moderator) was shouted down by pro-choicers. Meanwhile, the president-elect, who has been on both sides of the abortion question during his career, has already pledged to satisfy his pro-choice backers by requiring that any nominee to the Supreme Court be an explicit and public supporter of abortion rights.

I saw Jesse Jackson recently on a train, and we talked for quite a while about George Bush's awful nomination of Ed Carnes to the federal bench. An assistant attorney general in Alabama, Carnes built his reputation on sending people to "Yellow Mama," the state's electric chair. He would replace Frank Johnson, whom Martin Luther King once described as "the man who gave true meaning to the word justice." (A few weeks later Jackson joined the campaign to defeat the nomination. To no avail. Carnes was eventually confirmed.) I then asked Jackson about another form of execution. I told him that in speeches I often quote what he wrote as a pro-lifer. He looked uncomfortable. I asked him if he still believed what he said then.

"I'll get back to you on that," he said. He hasn't yet.

When a Baby Is HIV Positive

Netti Mayersohn, a member of the New York state legislature, is so forceful a feminist that in 1989 the state's chapter of the National Organization for Women named her Legislator of the Year.

This year, however, she is a pariah among many feminists and has been condemned by NOW for trying to invade the privacy rights of women who have just given birth. Also against her are the American Civil Liberties Union, AIDS lobbyists, and gay and lesbian groups.

Netti Mayersohn became a heretic when she introduced a bill in the assembly that would make a fundamental change in the testing of newborns that has been conducted by the state since 1987. All babies are tested to find out whether they have the HIV virus. The goal of the test is to track the spread of the epidemic. It is a blind test in that neither the mothers nor their doctors are offered the results.

As Mayersohn points out, "Seventy five percent of the newborns who are HIV positive at birth turn out not to be HIV cases. They have the mother's antibodies, which their own bodies throw off in a matter of months." The rest of the infants are actually HIV positive. That means a quarter of the 1,512 infants found positive in 10 New York state's blood test last year do have the virus.

Mayersohn's bill would ensure that mothers are notified if a baby is HIV positive and that the Health Department sees to it that all such infants get treatment.

To disclose that a baby has the virus, Mayersohn's opponents say, would mean that the mother is infected and has been tested without her consent. The effect would be to make the mother vulnerable to discrimination and stigmatization. Says Netti Mayersohn: "Countless people tell me that I will be destroying the "mother's privacy and also that she has the right not to know. They completely dismiss the fact that there is now another human life involved whose right to medical care—and, indeed to life—is being violated. It's a baby, not a statistic!"

The righteous myopia of her opponents continues to astonish and anger the assemblywoman. Look, she says, "The New York State Health Department and the Centers for Disease Control recommend that if a woman knows she is HIV infected, she should be warned not to breast feed the child." But these mothers are sent home from the hospital without being told that they are infected. Predictably, the state's AIDS Advisory Council—which has politicized the epidemic for years—opposes the passage of Mayersohn's bill. Also placing privacy over an infant's right to treatment is Gov. Mario Cuomo's handpicked state health commissioner, Mark Chassin.

The way to deal with this problem, these privacy protectors say, is to encourage women to be tested voluntarily. Accordingly, they have a bill requiring HIV counseling for pregnant women and new mothers. But if some women do not respond to counseling, well, that's life.

The rights of the child are irrelevant. Yet these are born children and therefore have the status of persons under the Constitution—with independent claims to due process and equal protection of the laws.

The governor, a noted ethicist, could make the difference in the state legislature. So far silent on this matter, he has not returned my calls. The governor is running for re-election.

Among the four dissenters from the AIDS Advisory Council report was Dr. Louis Z. Cooper, district chairman in New York state of the American Academy of Pediatrics. "Reliance on counseling," he says, "in order to encourage voluntary testing ignores the unacceptably high failure rate of such an approach." Thereby, infants are denied "access to life-saving and life-enhancing care."

A woman with a 4½-year-old son, blind-tested at birth, was not told then that he had the virus. He is now brain-damaged and cannot be fed except through a tube in his stomach. "They are sacrificing infants," she says of the AIDS establishment, "on the altar of confidentiality."

I asked the Centers for Disease Control how many states blind-test newborns for the HIV virus. "Forty-four," I was told. Has there been any controversy, any attempt to unblind the tests, in any of the states beside New York? No, I was told. And that is even more frightening than the resistance in New York to giving those infants a chance for a better life.

From the beginning of the epidemic, people with good motives have tried to protect those infected with the virus and those with AIDS from ostracism. But they have had only marginal concern for those who have unknowingly acquired the virus from people already infected. Infants too must be sacrificed on behalf of privacy.

Remembering Him

I knew Cardinal John O'Connor for many years. His death, however sad, is an occasion for me to think back on the extraordinary man I was privileged to call a friend.

He had two main passions. One was the sanctity of every individual life. That meant that he was pro-life, of course, in terms of opposing abortion. But it also meant that he subscribed to what Cardinal Joseph Bernardin of Chicago called the “seamless garment”: In short, if you were really pro-life, you had to be against not only abortion but also capital punishment, euthanasia and the effects of poverty on people both here in the U.S. and abroad.

Cardinal O'Connor was also as passionately pro-labor as any labor-union leader I've known—in part because his father was passionately pro-labor. I met him for the first time during a hospital strike, and the man running the consortium of hospitals, which included the Catholic hospitals, had decided to bring in strikebreakers. I heard O'Connor yelling in the corridor: “Over my dead body will you bring in scabs!”

He was heavily criticized by some major contributors to the church for having signed the pastoral letter on the economy, written by the Catholic bishops some years ago. His critics said he was advocating socialism. He responded: “I am a priest. There are at least 800,000 New Yorkers living in horrifying conditions. I am to do more than say Mass. I have to speak for them.”

He could be wonderfully funny, even under trying circumstances. Once, at a pro-life rally in Toronto, I suggested at a session I was moderating that there ought to be more research on contraception—not the kind that leads to abortion. Two angry members of the audience snatched the microphone from my hands and denounced me. Cardinal O'Connor was watching all this bemusedly. After I introduced him, he said, “I want you to know that I'm delighted that Nat is not a member of the church. We have enough trouble as it is.”

His humor was often self-deprecating, and he could be very sardonic, especially when it came to certain political figures. Whatever the subject, conversation with him was invigorating: His mind was sharp and his range of interests wide. (He reminded me of another man I knew very well, Justice William Brennan.) And he had an amazing presence: Anyone who talked to Cardinal O'Connor, in whatever setting, got the sense that he was the most important person in the room at the time.

I remember in particular one O'Connor homily at St. Patrick's: You can't

talk about filling people's souls, he said, unless you talk about filling their bellies. The only time I heard of the cardinal being visibly hurt, emotionally, occurred when he was walking down the street one day in Greenwich Village. As Cardinal O'Connor told it, a man—who it turned out had AIDS—said very bitter things to him. These wounding comments were aimed at someone who had set up hospital space for people with AIDS, and who sat up on many a night caring for them—not only talking with the patients but emptying their bedpans.

If I were giving a eulogy for John O'Connor, the four words I would use are: He was a mensch.

More Dangerous than a Monster:

Peter Singer Is Tenured

Despite some of her friends urging Harriet McBryde Johnson not to debate Peter Singer, she made the right choice—all the more so because that event led to a cover story by her in the New York *Times Magazine*. A chance for millions of readers to see, not in the abstract, but a living, very immediate refutation of Singer's lethal and influential utilitarian doctrine that certain lives are not worth living.

The late A. J. Muste, the direct-action pacifist—who was a key strategist in the anti-Vietnam-War movement and in many Gandhi-like ventures around the world—used to tell me he would “sup with the Devil” to see if he could find even a kernel of humanity in that Prince of Darkness.

In her *Times* article, Johnson did challenge this tenured apostle of “mercy” killings, but she wasted too much space being impressed by Singer's gentlemanly manners. Having supped with the Devil, A. J. Muste would not have been sidetracked even if Lucifer had discoursed on the infinite beauty of Beethoven's late quartets.

During one passage, Johnson writes, “We go back and forth for ten long minutes.” I would much rather have known more details of that dialogue—and the other disagreements between them at Princeton—than being told that she was “dazzled by his verbal facility.” He is so “respectful,” she continued, “so free of condescension, so focused on the argument, that by the time the show is over, I'm not exactly angry with him.”

I have interviewed Peter Singer at some length, and yes, he was reasonably courteous and attentive to my intensely fundamental disagreements with his view of “imperfect” human beings. And had the conversation not been on the phone, I'm sure he would have offered me tea. But I came away with no less a feeling of repugnance at his smugness at being so superior in his exercise of pure reason, shorn of sentimentality, in his lifework to remove unsightly persons for the greater good of the rest of us.

Singer did not condescend to me. I threw him off guard by telling him that my contrary views did not come from any religious impetus, but that I am an atheist. However, his invincible righteous smugness was there throughout the conversation, reminding me of the television debate I once had with bioethicist Dr. Alexander Morgan Capron, who had devised a “precise” mathematical formula

to determine which “damaged” infants should be allowed to survive.

I have described such bioethicists as Capron as being among “the new priesthood of death,” and Singer is the Archbishop. Singer’s influence on these transmogrifiers of “compassion” was illustrated in the *Cambridge Quarterly of Health Care Ethics* in the fall of 2000 when Capron—and another of that coven, Dr. Lawrence J. Schneiderman—wrote:

“A judge who orders that a severely disabled child be kept alive rarely sees firsthand the long-term continuing consequences of that decision, which remain a continuing vivid experience for the health care professionals who must care for the child.”

Such trauma, you see, can be avoided by disposing of the severely disabled child and, as Singer has counseled, by then advising the parents to try for better luck next time.

Had Johnson been less “dazzled by [Singer’s] verbal facility” and instead confronted him—and their audiences at Princeton—with Dr. Leo Alexander’s all too prophetic 1949 article, “Medical Science Under Dictatorship” (*The New England Journal of Medicine*), the readers of her article in the *Times* might have been more disturbed on their day of rest.

Elsewhere, Singer’s gentility becomes fractured when his views are compared with those of the Nazis. He is indeed not a Nazi, but I regret not having reminded him, in our interview, of Leo Alexander’s report that “the first direct order for euthanasia was issued by Hitler on September 1, 1939 . . . All state institutions were required to report on patients who had been ill five years or more and who were unable to work . . .

“The decisions regarding which patients should be killed were made entirely on the basis of this brief information by expert consultants, most of whom were professors of psychiatry in the key universities. *These consultants never saw the patients themselves.*” (Emphasis added.)

I wish Johnson, in writing of her “Unspeakable Conversations” for the large and influential New York *Times* audience, had pressed Singer more insistently on his responsibility—as the best known bioethicist in the world—for lives that have been ended summarily, and not only of infants, by those practicing utilitarians of death who do see the patients they kill, although they are unknown to Singer.

Official euthanasia is growing—The Netherlands, Belgium, Switzerland—as well as in more and more American hospitals, as Wesley Smith, an invaluable chronicler of “death with dignity,” has documented. Dr. Leo Alexander, shortly before his death in the 1980’s, warned that “the barriers against killing are coming down,” and Smith has become the preeminent illuminator of the accuracy of Alexander’s prophecy.

If Johnson gets another invitation to Princeton, I hope she first reads Wesley Smith's "The Clone Hustlers," in the Fall 2002 issue of this *Review*, in which he tells of another tenured Princeton professor, Lee Silver, in the biology department, who ardently proposes modifying human genes to create "new human beings." In that shining new world, as Smith notes, "the *ubermenschen* GenRich will utterly dominate the *untermenschen* Naturals" who will be taught only the skills necessary to serve the master race.

I think Johnson, while at times effectively countering Singer's own view of achieving human perfectibility, let him off too easily by spending too much space on his pleasant manners. That he is not a "monster" personally is irrelevant to the monstrous results of his cherished beliefs.

However, I do believe the article was very much worth the writing, and the positioning, in so widely read a publication. The lasting impression I believe it will have is that Johnson herself is a compelling refutation of Singer's blithe advocacy of the termination of "inferior" lives he will never see.

What is so vivid in her writing are the multiple dimensions of her active, engaged life—and her searching resilience, intelligence, and wit. She may have been too kind to Peter Singer, but now that he has actually met and seen her, I think and hope Harriet McBryde Johnson may appear, disconcertingly, in his dreams.

The following four columns appeared in the Village Voice and were reprinted in the Fall, 2003 issue of HLR with Mr. Hentoff's permission.

A Woman's Life Versus an Inept Press

The ACLU Supports a "Constitutional" Death by Starvation

November 6, 2003

We don't have full understanding of brain damage and consciousness . . . every patient is different . . . every patient's pattern of brain damage is different.

—Dr. Ross Bullock, Reynolds professor of neurosurgery at Virginia Commonwealth University, Richmond, Virginia, *Newsday*, October 26

I have covered highly visible, dramatic "right to die" cases—including those of Karen Ann Quinlan and Nancy Cruzan—for more than 25 years. Each time, most of the media, mirroring one another, have been shoddy and inaccurate.

The reporting on the fierce battle for the life of 39-year-old Terri Schiavo has been the worst case of this kind of journalistic malpractice I've seen.

On October 15, Terri's husband and legal guardian, Michael Schiavo, ordered the removal of her feeding tube. As she was dying, the Florida legislature and Governor Jeb Bush overruled her husband on October 21, and the gastric feeding tube has been reinserted pending further recourse to the court.

So intent is Michael Schiavo on having his wife die of starvation that one of his lawyers, after the governor's order to reconnect the feeding tube, faxed doctors in the county where the life-saving procedure was about to take place, threatening to sue any physician who reinserted a feeding tube. The husband had immediately gone to court to get a judge to revoke what the legislature and the governor had done.

The husband claims that he is honoring his marriage vows by carrying out the wishes of his wife that she not be kept alive by "artificial means." As I shall show, this hearsay "evidence" by the husband has been contradicted. The purportedly devoted husband, moreover, has been living with another woman since 1995. They have a child, with another on the way. Was that part of his marital vows?

For 13 years, Terri Schiavo has not been able to speak for herself. But she is not brain-dead, not in a comatose state, not terminal, and not connected to a respirator. If the feeding tube is removed, she will starve to death. Whatever she

may or may not have said, did she consider food and water “artificial means?”

The media continually report that Terri is in a persistent vegetative state, and a number of neurologists and bioethicists have more than implied to the press that “persistent” is actually synonymous with “permanent.” This is not true, as I shall factually demonstrate in upcoming columns. I will also provide statements from neurologists who say that if Terri were given the proper therapy—denied to her by her husband and guardian after he decided therapy was becoming too expensive despite \$750,000 from a malpractice suit—she could learn to eat by herself and become more responsive.

Terri is responsive, beyond mere reflexes. Having this degree of sentience, if she is starved to death, she will *not* “die in peace” as The New York *Times* predicts in an uninformed October 23 editorial supporting the husband. What happens to someone who can feel pain during the process of starvation is ghastly.

Increasingly, New York *Times* editorials are not as indicative of conscious liberal “bias” as they are of ignorance or denial of the facts, as I have demonstrated in my series on Judge Charles Pickering.

In all the stories on Terri Schiavo and her parents’ determined efforts to save her life, the media continually report that the Florida legislature intervened because of many thousands of calls, letters, and e-mails from the Christian right and pro-lifers. Those groups and individuals are indeed a major factor in rousing support to prevent Terri from being starved to death. But among the many others who sent urgent messages are disabled Americans and their organizations.

Except for the op-ed page article by Stephen Drake of the Not Dead Yet organization in the October 29 *Los Angeles Times* (“Disabled Are Fearful: Who Will Be Next?”) and a letter in the October 24 New York *Times*, I have seen hardly any mention in the press of the deeply concerned voices of the disabled, many of whom, in their own lives, have survived being terminated by bioethicists and other physicians who strongly believe that certain lives are not worth living. The numbers of these “new priesthoods of death,” as I call them, are increasing.

The letter to The New York *Times* signed by Max Lapertosa, staff counsel, Access Living in Chicago—told of “14 national disability organizations that filed a friend-of-the-court brief to support keeping Terri Schiavo alive.” Lapertosa objected to a *Times* editorial calling for Terri to go gently into that good night because, said the moral philosophers of the *Times*, “true respect for life includes recognizing . . . when it ceases to be meaningful.”

Max Lapertosa reminded Gail Collins’s board of oracles at the *Time*’s editorial page that “many would lump into this category [of meaningless lives] people with severe autism, multiple sclerosis or cerebral palsy who, like Mrs. Schiavo, are nonverbal and are often described as being ‘in their own world.’”

“The judicial sanctioning of such attitudes,” Lapertosa continued, “moves America

back to the days when the sterilization and elimination of people with disabilities did not merely reflect private prejudices but were embraced as the law of the land.”

In the Los Angeles *Times*' October 29 op-ed piece by Stephen Drake, he writes: “I was born brain-damaged as a result of a forceps delivery. The doctor told my parents I would be a ‘vegetable’ for the rest of my life—the same word now being used for Schiavo—and that the best thing would be for nature to take its course. They refused. Although I had a lot of health problems, surgeries and pain as a child, I went on to lead a happy life.” And clearly, his is a very articulate life. I have interviewed other such “vegetables.”

Ignoring the facts of the case, the American Civil Liberties Union—to my disgust, but not my surprise in view of the long-term distrust of the ACLU by disability rights activists—has marched to support the husband despite his grave conflicts of interests in this life-or-death case. The ACLU claims the governor and the legislature of Florida unconstitutionally overruled the courts, which continued to declare the husband the lawful guardian. On the other hand, the ACLU cheered when Governor George Ryan of Illinois substituted his judgment for that of the courts by removing many prisoners from death row. In a later column, I'll go deeper into the constitutional debate over saving Terri's life.

In the October 28 *weeklystandard.com*, Wesley Smith, author of *Forced Exit*—who has accurately researched more of these cases than anyone I know—reports that of the \$750,000 to be held in trust for Terri's rehabilitation, two of Michael Schiavo's lawyers pressing for removal of her feeding tube have been paid more than \$440,000. Whom did that rehabilitate? Any comment from the ACLU? If the husband and the lawyers succeed, maybe the ACLU will send flowers to Terri's funeral.

Was Terri Schiavo Beaten in 1990?

Will There Be an Investigation in Time?

November 14, 2003

There is a new dimension in the fierce battle over whether Terri Schiavo's life is worth saving. A federally funded investigation has begun into certain medical judgments made by her husband and guardian, Michael Schiavo, including decisions in recent months. But more important is whether the inquiry will discover what actually caused Terri Schiavo's alleged cardiac arrest in 1990, which is said to be the reason her brain was deprived of oxygen, resulting in her condition for the past 13 years.

The degree to which this investigation is widely reported by the media may

help determine whether Terri Schiavo lives or dies. Her husband is in court again to demand that her feeding tube be removed once more.

If the courts continue to support the husband, she may die before the investigation is completed. But even in that case, the results may lead to a change of state laws that could save other lives.

Conducting the investigation is the Advocacy Center for Persons With Disabilities (ACPD). Its website says it is “Florida’s protection and advocacy program for persons with disabilities.” As reported by Jeff Johnson on *cnsnews.com* (October 29), the agency has, according to its website, “the authority to investigate incidents of abuse and neglect when reported if there is probable cause to believe the incidents occurred.”

As Jeff Johnson writes, “How quickly ACPD makes a determination will depend on how difficult it is for the agency to gain access to Mrs. Schiavo’s medical records and to the people it needs to interview on both sides of the legal battle.”

I have learned that ACPD has sent Michael Schiavo’s lawyer a request that he authorize the release of Terri Schiavo’s medical records. There was initial resistance, but the records have been turned over.

What gives this investigation the potential for a dramatic reassessment of previous court decisions on the legitimacy of Michael Schiavo’s guardianship is in the lead of Jeff Johnson’s story: “The Schindler family [Terri Schiavo’s parents, who are fighting for her life] has found a new ally in the battle—one it did not seek out—in the person of a famed New York forensic pathologist, Dr. Michael Baden.” Former chief medical examiner for the city of New York and co-director of the Medicolegal Investigation Unit of the New York State Police, Dr. Baden is often quoted in news reports and interviewed on television.

In one such interview on Fox News Channel’s *On the Record With Greta Van Susteren*, I heard Baden agree with a panel of lawyers that Terri Schiavo is in a persistent vegetative state, and will not recover. But on a subsequent October 24 appearance on that program, Dr. Baden had a different perspective on the origins of the Terri Schiavo case.

Baden had now seen a 1991 bone-scan report that cast considerable doubt on a claim in Michael Schiavo’s successful medical malpractice suit, that Terri’s brain injury was caused by a potassium imbalance that led to a heart attack depriving her brain of oxygen.

Dr. Baden, who has written three books on forensic pathology, told Van Susteren: “It’s extremely rare for a 20-year-old to have a cardiac arrest from low potassium who has no other diseases . . . which she doesn’t have. . . . The reason that she’s in the state she’s in is because there was a period of time, maybe five or eight minutes, when not enough oxygen was going to her brain. That can happen because the heart stops for five or eight minutes, *but she had a*

healthy heart from what we can see.” (Emphasis added).

Dr. Baden then addressed the 1991 bone-scan report on Terri Schiavo, which was completed on March 5 of that year by Dr. W. Campbell Walker in order to “evaluate for trauma” that may have been caused by a suspected “closed head injury.” In the report, Walker wrote:

“This patient has a history of trauma. The presumption is that the other *multiple areas of trauma also relate to previous trauma.*” (Emphasis added).

Here we get to what focused Dr. Baden’s attention. On cnsnews.com, Jeff Johnson reported, “Walker listed apparent injuries to the ribs, thoracic vertebrae, both sacroiliac joints, both ankles and both knees.”

In his interview with Greta Van Susteren, Dr. Baden noted “that the bone scan describes her having a head injury . . . and head injury can lead to the ‘vegetative state’ that Mrs. Schiavo is in now.”

But, Baden continued, the bone scan “does show evidence that there are other injuries, other bone fractures that are in a healing stage [in 1991].”

Those injuries could have happened, Baden continued, from “some kind of trauma. The trauma could be from an auto accident, the trauma could be from a fall, or the trauma could be from some kind of beating that she obtained from somebody somewhere. *It’s something that should have been investigated in 1991 . . . and maybe [it was] by police at that time.*” (Emphasis added).

Why not see if there was a police report on those traumas to Terri in 1990? The Advocacy Center for Persons With Disabilities should look into this during its investigation of possible incidents of abuse and neglect of Terri. Moreover, Pamela Hennessy, spokesperson for Terri’s parents and her brother, told cnsnews.com, “This is what the family and their doctors have been saying for a number of years.”

I asked Hennessy to clarify that statement. “From the beginning,” she told me, “they had serious doubts as to the reason for Terri’s collapse. Then, when they first heard about the bone-scan report in November of last year, they tried to file a report with the police on a possible battery on Terri. But the police wouldn’t help them.”

The family believes that after Terri and her husband had a violent argument earlier on the evening she collapsed, Terri might have been strangled later that night. Says Pat Anderson, the lawyer for Terri’s parents:

“Governor Jeb Bush should order the state-wide prosecutor of Florida to convene a jury to investigate all of this.” And the Advocacy Center for Persons With Disability has that 1991 bone-scan report. Will the courts wait for the investigations—or hurry to send her into eternity? Should Michael Schiavo have the guardianship power to terminate her?

It's Not Only About Terri Schiavo

Barriers to Killing Come Down

November 21, 2003

People already have the right to refuse unwanted treatment, and suicide is not illegal. What we oppose is a public policy that singles out individuals for legalized killing based on their health status. This violates the Americans With Disabilities Act, and denies us equal protection of the laws.

Disability opposition to this ultimate form of discrimination has been ignored by most media and courts, but countless people with disabilities have already died before their time.

—Not Dead Yet: The Resistance, a disability rights organization,
Forest Park, Illinois, October 28, 2003

In 1920, a prominent German lawyer, Karl Binding, and a distinguished German forensic psychiatrist, Alfred Hoche, wrote a brief but deadly book, *The Permission To Destroy Life Unworthy of Life*. In his new book, *The Coming of the Third Reich* (Penguin), Richard Evans notes that Binding and Hoche emphasized that “the incurably ill and the mentally retarded were costing millions of marks and taking up thousands of much-needed hospital beds. So doctors should be allowed to put them to death.”

Then came Adolf Hitler, who thought this was a splendid, indeed capital, idea. The October 1, 2003, New York *Daily News* ran this Associated Press report from Berlin:

“A new study reveals Nazi Germany killed at least 200,000 people because of their disabilities—people deemed physically inferior, said a report compiled by Germany’s Federal Archive. Researchers found evidence that doctors and hospital staff used gas, drugs and *starvation* to kill disabled men, women and children at medical facilities in Germany, Austria, Poland and the Czech Republic. . . .

“The Nazis launched the drive to root out what they called ‘worthless lives’ [and ‘useless eaters’] in the summer of 1939, *pre-dating their full-scale organization of the Holocaust, in which they killed 6 million Jews.*” (Emphasis added).

The more than 200,000 “worthless lives” terminated by the Nazis before the Holocaust included few Jews. Most of those killed were other Germans considered unfit to be included in “the master race.”

Among the defendants at the Nuremberg trials of Nazi leaders and their primary accomplices in the mass murder were German doctors who had gone along

with the official policy of euthanasia. An American doctor, Leo Alexander, who spoke German, had interviewed the German physician-defendants before the trials, and then served as an expert on the American staff at Nuremberg.

In an article in the July 14, 1949, *New England Journal of Medicine*, Dr. Alexander warned that the Nazis' crimes against humanity had "started from small beginnings . . . merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived." That shift in emphasis among physicians, said Dr. Alexander, could happen here, in America.

Actually, the devaluing of apparent "imperfect life" had begun years before, in the United States. Various academics, in and out of the medical profession, had successfully advocated and instituted a eugenics movement—the perfecting of future generations of Americans by deciding who, depending on their hereditary genes, would be allowed to have children. The unfit would no longer be permitted to reproduce.

These American eugenicists provided German proponents of a "master race" with inspiration. As Robert Jay Lifton wrote in his invaluable book *The Nazi Doctors* (Basic Books), "A rising interest in eugenics [in America had] led, by 1920, to the enactment of laws in twenty-five states providing for compulsory sterilization of the criminally insane and *other people considered genetically inferior*." (Emphasis added).

Paying attention in Germany, Heinrich Himmler, one of Hitler's executioners, said the Nazis were "like the plant-breeding specialist who, when he wants to breed a pure new strain . . . goes over the field to cull the unwanted plants." Under the Nazis, there were eugenics courts to decide who could have children. In the United States Supreme Court (*Buck v. Bell*, 1927), Justice Oliver Wendell Holmes, ruling that 18-year-old Carrie Buck should be involuntarily sterilized, famously wrote:

"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 of their kind. . . . Three generations of imbeciles are enough." Only Justice Pierce Butler dissented.

In this country, the eugenics movement lost its cachet for a time because the Nazis had gone from sterilization of the disabled to herding the religiously, racially, and politically unfit into gas chambers.

But there has been an American revival of eugenics in certain elite circles. A few years ago, an archconservative who had talked with some of the present-day, would-be purifiers of the American stock told me they were delighted at the deaths from AIDS of homosexuals.

But to protect the disabled from "mercy" killings, as well as eugenicists,

another movement was forming here. Not long before he died, Dr. Alexander read an article in the April 12, 1984, *New England Journal of Medicine* by 10 physicians—part of the growing “death with dignity” brigade. They were from such prestigious medical schools as Harvard, Johns Hopkins, and the University of Virginia. These distinguished healers wrote that when a patient was in a “persistent vegetative state,” it was “morally justifiable” to “withhold antibiotics and artificial nutrition (feeding tubes) and hydration, as well as other forms of life-sustaining treatment, allowing the patient to die.” They ignored the finding that not all persistent vegetative states are permanent.

After reading the article, Dr. Alexander said to a friend: “It is much like Germany in the ’20s and ’30s. The barriers against killing are coming down.”

Next week: The growing conviction among American doctors, bioethicists, and hospital ethics committees that it is “futile” to try to treat certain patients, and therefore, medical professionals should have the power to decide—even against the wishes of the family—when to allow these valueless lives to end.

If the courts finally permit the husband of brain-damaged Terri Schiavo to continue to press for her death by starvation—by again removing her feeding tube—more of the barriers to killing may come down in other states. So this isn’t only about Terri Schiavo. It could be about you.

The Culture of Death

Who Will Decide When You Should Die?

December 1, 2003

Ironically, the “right to die” movement was founded on the premise that patients and/or families are the best judges of when it is time to die. Now, however, we are being told that doctors and/or ethicists are really the best judges of when we should die.

—Nancy Valko, journalist, medical ethicist, and intensive care unit nurse, “Bioethics Watch,” *Voices*, 2003

Bob Schindler [father of Terri Schiavo] poignantly observes, “We pay great lip service in this country to disability rights, but as the degree of a person’s disability increases, the level of legal protection that person receives decreases.”

—Nancy Valko, lifeissues.net, August 2003

In a November 4, 2002, story in *The Philadelphia Inquirer*, “Penn Hospital to Limit Its Care in Futile Cases,” Stacey Burling reported that the ethics committee of the University of Pennsylvania Hospital had approved new guidelines which stated, “intensive care would not routinely be given to patients in a persistent vegetative or minimally conscious state. Only patients who had explicitly requested such care would get it.” This *exclusion from rehabilitative or other forms of life-enhancing treatment* will apply to “patients with severe brain damage.”

These patients, for whom the hospital and its ethics committee have abandoned hope, would not even be admitted to an ICU (intensive care unit).

In David Caruso’s Associated Press report (December 12, 2002) on this last mile for patients at the University of Pennsylvania Hospital, he quoted Stephen Gold, a lawyer in Philadelphia who specializes in representing people with disabilities.

Noting this discounting of the lives of patients who cannot speak for themselves and have not written advance directives, Gold said that the University of Pennsylvania Hospital, and other institutions that now have similar policies, might also consider cutting off intensive care for people without health insurance or who have other handicaps beyond present guidelines.

“It is a slippery slope they are going down,” Gold continued. “If we have a way to provide a medical treatment for people that will keep them alive, we should always provide it, unless they have a living will saying we shouldn’t.”

Gold also told the Associated Press, “Not everyone agrees on what constitutes a life worth living. I had a client with cerebral palsy once who was asked to sign a do not resuscitate order [do not revive the patient].” But that patient had gone into the hospital “to be treated for appendicitis.”

Wesley J. Smith, an expert on the growing culture of death that is being proposed and implemented by hospitals and bioethicists, makes the chilling point: “Now, a new medical hegemony is arising, one that proclaims the right to declare which of us have lives worth living and are therefore worth treating medically, and which of us do not.

“Unless people object strongly . . . to this duty to die . . . and legislatures take active steps to intervene, this new and deadly game of ‘Doctor Knows Best’ will be coming soon to a hospital near you.”

Wes is one of the writers and researchers I consult on this nationwide movement to get the public to endorse legal euthanasia for those who would be “better off dead,” as certain bioethicists say of patients for whom more treatment is “futile.” I strongly recommend Smith’s revised and updated *Forced Exit* (Spence Publishing Company, 111 Cole Street, Dallas, TX 75207; also available on amazon.com).

Another specialist in these life-or-death matters whom I have relied on for many years is Nancy Valko. She not only writes extensively and gives work-

shops on medical ethics, but actually also works full-time in the intensive care unit at a county hospital in St. Louis.

Among Valko's nursing specialties are oncology, kidney machines, trauma, cardiac and cancer care, and patients who may or may not be in a persistent vegetative state. Therefore, she is continually on the front line of the kinds of issues involved in Terri Schiavo's case, and the many more to come.

In an article ("Futility Policies and the Duty to Die," *Voices*, "Bioethics Watch," wf-f.org), she writes:

"This theory [that some lives are no longer worth living] has now evolved into 'futile care' policies at hospitals in Houston, Des Moines, California and many other areas. Even Catholic hospitals are now becoming involved. . . . Thus, the 'right to die' becomes the 'duty to die,' with futile care policies offering death as the only 'choice.' . . . A poor prognosis, which can be erroneous and is seldom precise, will become a death sentence."

I have debated bioethicists who are true believers in the "duty to die" when care is "futile." These exchanges have been on college campuses, radio, and television. When I bring up the history of "futile care" in pre-Hitler Germany (as I did in last week's column), the "duty to die" advocates become deeply offended. Nonetheless, they are sincerely continuing a lethal legacy.

Nancy Valko continues: "Just a generation ago, doctors and nurses were ethically prohibited from hastening or causing death. Family disputes and ethically gray situations occurred, but certain actions such as withdrawing medically assisted food and water from a severely brain-damaged but non-dying person were considered illegitimate no matter who was making the decision.

"But," Nancy Valko emphasizes, "with the rise of the modern bioethics movement, life is no longer assumed to have the intrinsic value it once did, and 'quality of life' has become the overriding consideration. Over time, the ethical question, 'what is right?' became 'who decides?'—which now has devolved into 'what is legally allowed?'"

In the aforementioned November 4 *Philadelphia Inquirer* story, Stacey Burling reported what physicians and bioethicists consider a worrisome obstacle to expanding "what is legally allowed."

"Hospital leaders [around the country] fear they would lose a lawsuit if they denied care demanded by a family." These officials and bioethicists want more case law to enable them to end lives they consider "futile."

Until the media spend more space and care on who decides whether—and how—certain disabled Americans should die, I recommend your remembering that, as disability rights activists say, many of us are only temporarily able.

Whose Lives Are Worth Continuing?

On October 17, at the commemoration of the fifth anniversary of the death of J.P. McFadden, William Buckley Jr. challenged the *Human Life Review*—and presumably its readers as well as its editors—to consider whether the lives of “insensate persons” should be sustained by “heroic therapy” with resultant “great strains on doctors, family, and friends.”

While he conceded that not all such cases are “clear cut,” the thrust of his concern, in view of “the unique boost to longevity brought on by science,” was that we must confront the real possibility that certain lives are no longer worth continuing.

He mentioned “a woman for several years stricken into physical and mental immobility. Artificially administered sustenance keeps her alive. Her husband wishes, after years of standing by, to activate her death from malnutrition. Her parents argue against that measure.”

The woman, still alive as I write—despite the persistent, ardent attempts by her husband, Michael Schiavo, to have her feeding tube removed, is Terri Schiavo. Mr. Buckley—like the American Civil Liberties Union, which is aggressively supporting the husband’s wishes—clearly has not investigated the facts of the case, and that underlines how far from “clear cut” this and many other such cases are.

Terri Schiavo is not brain dead, is not in a comatose state, is not terminal, and is not connected to a respirator. If her feeding tube is removed, she will starve to death. Her husband insists that he is honoring her wishes before she fell ill—a story contradicted by a close friend who heard Terri Schiavo express exactly the opposite desire. Her husband says she did not want to be kept alive by “artificial means.” If she did say that, did she mean food and water as “artificial means?”

Contrary to reports by the press, she is not in a “persistent vegetative state”; and even if she were, “persistent” is not synonymous with “permanent,” as has been shown by recoveries of patients diagnosed with that condition.

Her “devoted” husband has been living with another woman for years, and with her, he has a child, with another on the way. He has spent a considerable amount of the \$750,000 awarded in a malpractice suit about the care that led to Terri’s condition on lawyers relentlessly trying to get her feeding tube removed. Michael Schiavo once succeeded in accomplishing that. Her life was saved by Florida governor Jeb Bush and the Florida legislature by a law that kept her alive but is strenuously being contested on constitutional grounds by the ACLU and Michael Schiavo.

A *New York Times* editorial called for Terri Schiavo to go gently into the

good night because—as Mr. Buckley appears to suggest—“true respect for life includes recognizing . . . when it ceases to be meaningful.”

But, as Max Lapertosa, staff counsel for the disability rights organization, Access Living in Chicago, wrote to the *Times*: “Many would lump into this category [of meaningless lives] people with severe autism, multiple sclerosis or cerebral palsy who, like Mrs. Schiavo, are nonverbal and are often described as being ‘in their own world.’”

Mr. Buckley may greatly underestimate how far from “clear cut” these so-called “end of life” situations actually are.

In the Schiavo case, a disability group I have known and respected for years—Not Dead Yet—reminds us: “People have the right to refuse unwanted treatment, and suicide is not illegal. What we oppose is a public policy that singles out individuals for legalized killing [or “mercy” killing] based on their health status . . . This denies us equal protection of the laws.”

The people Mr. Buckley spoke to on October 17 know—as does Mr. Buckley—how dangerously the respect for life has been eroded by proponents of abortion, assisted suicide, and quiet as it’s kept, a growing number of advocates of eugenics and indeed euthanasia. Professor Peter Singer—a subject of a number of *Human Life Review* articles—is far from alone.

And, as Wesley Smith has documented in these pages, and elsewhere, the increasing authority and power of bioethicists and hospital “ethics” committees have created a lethal mindset that, to give one example among many, has led to this result:

The ethics committee of the University of Pennsylvania Hospital approved, in 2002, guidelines which stated that “intensive care would not be routinely given to patients in a persistent vegetative or minimally conscious state. Only patients who had explicitly requested such care would get it.”

Terri Schiavo did not have a signed advance directive as to her wishes if a time came when she could not speak for herself. We have only the testimony of her ethically challenged husband as to what those wishes were.

For years, I have consulted on these matters with Nancy Valko, who not only writes extensively and gives workshops on medical ethics, but actually also works full-time (she has great energy) in the intensive care unit of a county hospital in St. Louis. To recall the title of a former television program created by Mr. Buckley—a program I greatly miss—Nancy Valko speaks from the firing line:

“Just a generation ago, doctors and nurses were ethically prohibited from hastening or causing death. Family dispute and ethically gray situations occurred, but certain actions such as withdrawing medically assisted food and water from a severely brain-damaged but non-dying person were considered

illegitimate no matter who was making the decision.

“But,” Nancy Valko reminds us, and Mr. Buckley, “with the rise of the modern bioethics movement, life is no longer assumed to have the intrinsic value it once did, and ‘quality of life’ has become the overriding consideration. Over time, the ethical question, ‘what is right?’ became ‘who decides?’—which now has devolved into ‘what is legally allowed?’”

I, like Mr. Buckley, am pro-life. But, as the late Cardinal Joseph Bernardin illuminated in his “seamless garment” definition of that commitment, being pro-life encompasses more than the killing fields of abortion.

Terri Schiavo: Judicial Murder

For all the world to see, a 41-year-old woman, who has committed no crime, will die of dehydration and starvation in the longest public execution in American history.

She is not brain-dead or comatose, and breathes naturally on her own. Although brain-damaged, she is not in a persistent vegetative state, according to an increasing number of radiologists and neurologists.

Among many other violations of her due process rights, Terri Schiavo has never been allowed by the primary judge in her case—Florida Circuit Judge George Greer, whose conclusions have been robotically upheld by all the courts above him—to have her own lawyer represent her.

Greer has declared Terri Schiavo to be in a persistent vegetative state, but he has never gone to see her. His eyesight is very poor, but surely he could have visited her along with another member of his staff. Unlike people in a persistent vegetative state, Terri Schiavo is indeed responsive beyond mere reflexes.

While lawyers and judges have engaged in a minuet of death, the American Civil Liberties Union, which would be passionately criticizing state court decisions and demanding due process if Terri were a convict on death row, has shamefully served as co-counsel for her husband, Michael Schiavo, in his insistent desire to have her die.

Months ago, in discussing this case with ACLU executive director Anthony Romero, and later reading ACLU statements, I saw no sign that this bastion of the Bill of Rights has ever examined the facts concerning the egregious conflicts of interest of her husband and guardian Michael Schiavo, who has been living with another woman for years, with whom he has two children, and has violated a long list of his legal responsibilities as her guardian, some of them directly preventing her chances for improvement. Judge Greer has ignored all of them.

In February, Florida's Department of Children and Families presented Judge Greer with a 34-page document listing charges of neglect, abuse, and exploitation of Terri by her husband, with a request for 60 days to fully investigate the charges. Judge Greer, soon to remove Terri's feeding tube for the third time, rejected the 60-day extension. (The media have ignored these charges, and much of what follows in this article.)

Michael Schiavo, who says he loves and continues to be devoted to Terri, has provided no therapy or rehabilitation for his wife (the legal one) since 1993. He did have her tested for a time, but stopped all testing in 1993. He insists she once told him she didn't want to survive by artificial means, but he didn't men-

tion her alleged wishes for years after her brain damage, while saying he would care for her for the rest of his life.

Terri Schiavo has never had an MRI or a PET scan, nor a thorough neurological examination. Republican Senate leader Bill Frist, a specialist in heart-lung transplant surgery, has, as *The New York Times* reported on March 23, “certified [in his practice] that patients were brain dead so that their organs could be transplanted.” He is not just “playing doctor” on this case.

During a speech on the Senate floor on March 17, Frist, speaking of Judge Greer’s denial of a request for new testing and examinations of Terri, said reasonably, “I would think you would want a complete neurological exam” before determining she must die.

Frist added: “The attorneys for Terri’s parents have submitted 33 affidavits from doctors and other medical professionals, all of whom say that Terri should be re-evaluated.”

In death penalty cases, defense counsel for retarded and otherwise mentally disabled clients submit extensive medical tests. Ignoring the absence of complete neurological exams, supporters of the deadly decisions by Judge Greer and the trail of appellate jurists keep reminding us how extensive the litigation in this case has been—19 judges in six courts is the mantra. And more have been added. So too in many death penalty cases, but increasingly, close to execution, inmates have been saved by DNA.

As David Gibbs, the lawyer for Terri’s parents, has pointed out, there has been a manifest need for a new federal, Fourteenth Amendment review of the case because Terri’s death sentence has been based on seven years of “fatally flawed” state court findings—all based on the invincible neglect of elementary due process by Judge George Greer.

I will be returning to the legacy of Terri Schiavo in the weeks ahead because there will certainly be long-term reverberations from this case and its fracturing of the rule of law in the Florida courts and then the federal courts—as well as the disgracefully ignorant coverage of the case by the great majority of the media, including such pillars of the trade as *The New York Times*, *The Washington Post*, *The Miami Herald*, and the *Los Angeles Times* as they copied each other’s misinformation, like Terri Schiavo being “in a persistent vegetative state.”

Do you know that nearly every major disability rights organization in the country has filed a legal brief in support of Terri’s right to live?

But before I go back to other Liberty Beats—the CIA’s torture renditions and the whitewashing of the landmark ACLU and Human Rights First’s lawsuit against Donald Rumsfeld for his accountability in the widespread abuse of detainees, including evidence of torture—I must correct the media and various “qualified experts” on how a person dies of dehydration if he or she is sentient, as Terri Schiavo demonstrably is.

On March 15's *Nightline*, in an appallingly one-sided, distorted account of the Schiavo case, Terri's husband, Michael—who'd like to marry the woman he's now living with—said that once Terri's feeding tube is removed at his insistent command, Terri "will drift off into a nice little sleep and eventually pass on and be with God."

As an atheist, I cannot speak to what he describes as his abandoned wife's ultimate destination, but I can tell how Wesley Smith (consultant to the Center for Bioethics and Culture)—whom I often consult on these bitterly controversial cases because of his carefully researched books and articles—describes death by dehydration.

In his book *Forced Exit* (Times Books), Wesley quotes neurologist William Burke: "A conscious person would feel it [dehydration] just as you and I would. . . . Their skin cracks, their tongue cracks, their lips crack. They may have nosebleeds because of the drying of the mucous membranes, and heaving and vomiting might ensue because of the drying out of the stomach lining.

"They feel the pangs of hunger and thirst. Imagine going one day without a glass of water! . . . It is an extremely agonizing death."

On March 23, outside the hospice where Terri Schiavo was growing steadily weaker, her mother, Mary, said to the courts and to anyone who would listen and maybe somehow save her daughter:

"Please stop this cruelty!"

While this cruelty was going on in the hospice, Michael Schiavo's serpentine lawyer, George Felos, said to one and all: "Terri is stable, peaceful, and calm. . . . She looked beautiful."

During the March 21 hearing before Federal Judge James D. Whittemore, who was soon to be another accomplice in the dehydration of Terri, the relentless Mr. Felos, anticipating the end of the deathwatch, said to the judge:

"Yes, life is sacred, but so is liberty, your honor, especially in this country."

It would be useless, but nonetheless, I would like to inform George Felos that, as Supreme Court Justice William O. Douglas said: "The history of liberty is the history of due process"—fundamental fairness.

Contrary to what you've read and seen in most of the media, due process has been lethally absent in Terri Schiavo's long merciless journey through the American court system.

"As to legal concerns," writes William Anderson—a senior psychiatrist at Massachusetts General Hospital and a lecturer at Harvard University—"a guardian may refuse any medical treatment, but drinking water is not such a procedure. It is not within the power of a guardian to withhold, and not in the power of a rational court to prohibit."

Ralph Nader agrees. In a statement on March 24, he and Wesley Smith (au-

thor of, among other books, *Culture of Death: The Assault of Medical Ethics in America*) said: “*The court is imposing process over justice. After the first trial [before Judge Greer], much evidence has been produced that should allow for a new trial—which was the point of the hasty federal legislation.*

“If this were a death penalty case, this evidence would demand reconsideration. Yet, an innocent, disabled woman is receiving less justice. . . . This case is rife with doubt. Justice demands that Terri be permitted to live.” (Emphasis added.)

But the polls around the country cried out that a considerable majority of Americans wanted her to die without Congress butting in.

A March 20 ABC poll showed that 60 percent of the 501 adults consulted opposed the ultimately unsuccessful federal legislation, and only 35 percent approved. Moreover, 70 percent felt strongly that it was wrong for Congress to get into such personal, private matters—and interfere with what some advocates of euthanasia call “death with dignity.” (So much for the Fourteenth Amendment’s guarantee of due process and equal protection of the laws.)

But, as Cathy Cleaver Ruse of the Secretariat for Pro-Life Activities of the United States Conference of Catholic Bishops pointed out:

“The poll [questions] say she’s ‘on life support,’ which is not true [since all she needs is water], and that she has ‘no consciousness,’ which her family and dozens of doctors dispute in sworn affidavits.”

Many readers of this column are pro-choice, pro-abortion rights. But what choice did Terri Schiavo have under our vaunted rule of law—which the president is eagerly trying to export to the rest of the world? She had not left a living will or a durable power of attorney, and so could not speak for herself. But the American system of justice would not slake her thirst as she, on television, was dying in front of us all.

What kind of a nation are we becoming? The CIA outsources torture—in violation of American and international law—in the name of the freedoms we are fighting to protect against terrorism. And we have watched as this woman, whose only crime is that she is disabled, is tortured to death by judges, all the way to the Supreme Court.

And keep in mind from the Ralph Nader-Wesley Smith report: “The courts . . . have [also] ordered that no attempts be made to provide her water or food by mouth. Terri swallows her own saliva. Spoon feeding is not medical treatment. This outrageous order proves that the courts are not merely permitting medical treatment to be withheld, they have ordered her to be made dead.”

In this country, even condemned serial killers are not executed in this way.

[N.B.: *The first six of the following seven articles appeared in The Village Voice consecutively, beginning with the Dec. 6, 1983 issue and continuing through the Jan. 10, 1984 issue; the seventh article first appeared in the April 3, 1984 issue.*

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We have included Mr. McFadden's original "special section" introduction here as it appeared in the Spring, 1984 Issue of HLR.

Nat Hentoff on the Babies Doe

The primary concern of this journal has been abortion. But we have also published a great deal for a decade now, on infanticide—specifically arguments that abortion on demand would inevitably lead to widespread killing of born babies: if “unwanted” preborns may be put to death, why not unwanted or “imperfect” newborns? The moral difference is nil. But a difference does remain: whereas the U.S. Supreme Court has legalized abortion, American law still forbids infanticide, even if it has ceased acting to prevent or punish it.

In effect, the current controversy over infanticide began in 1982, because of nationally-publicized efforts to prevent the death of the “original” baby Doe, in Bloomington, Indiana. In a word, infanticide became *news*.

How that news has been reported—and *not* reported—is the substance of the remarkable series of articles that follows here. Mr. Nat Hentoff, the author, is an unusual journalist by any standard. A prolific writer on a broad range of subjects, he considered himself what used to be called a Man of the Left, and, preeminently, a civil libertarian, allegiances which would seem to fit him comfortably for his journalistic base, *The Village Voice*, New York City’s “radical” weekly.

The question arises: Why did Mr. Hentoff not write about infanticide before now? Surely *born* babies are citizens with civil rights? We asked him that question, not least because we wondered if his answer would be that he was pro-abortion, and so had avoided (as many others have) the moral nexus between the two issues. No, Hentoff said, he was not pro-abortion; he simply had not “got into” either abortion or infanticide, which are, admittedly, distasteful subjects (and he agreed that the point of Mr. Sobran’s title “The Averted Gaze” might well apply to him). What *did* get Hentoff into the controversy was the recent case of Baby Jane Doe: the more he read about it, he said, the more convinced he became that the news re-

ports were strangely similar (“everybody was saying the same thing”) and less than accurate. For almost nobody was saying anything about what one local reporter had noticed: that a doctor in the very same hospital where Baby Jane still lies (at this writing) had given a quite different opinion of her condition from those appearing in the “standard” versions. Why?

Mr. Hentoff set out to answer that question. He did so in what we would describe as the Grand Tradition of the old-fashioned newspaperman: he made calls, re-checked facts, made more calls, pursued new leads, sought out opinions both expert and ordinary. His conclusion: “This was a clear case of people getting misleading information because they were not getting the complete story.”

Hentoff also read voluminously, assembling a mass of facts and information of heroic proportions (certainly his research went far beyond anything the reader can expect from most other journalists nowadays?). And then he did what he does best of all: he wrote his story.

Our original intention was to provide you, dear reader, with the “best” excerpts. But the more we read, the more it seemed to us that Mr. Hentoff weaves seamless stuff that should unfold just as he wrote it (even though the way he wrote it—in full-page columns, over the six-week period from the Dec. 6, 1983 through Jan. 10, 1984 issues of the *Voice*—plus a seventh column in the April 3, 1984 issue—made necessary some repetitions). Thus we have reprinted *all* of it here, with the permission of the author and the publisher (©1983,1984 The *Village Voice*).

In our judgement, Mr. Hentoff has produced a classic piece of investigative reporting. And, believe it or not, there is more to come: he has already written several columns on an abortion-related story and (he tells us) may begin a whole new series shortly. We hope that we will be able to provide more of this continuing saga in future issues, but we hope most of all that you will not fail to read the historic document you have on hand right now.

J.P. McFadden, *Editor*

Big Brother and the Killing of Imperfect Babies

Political language...is designed to make lies sound truthful and murder respectable, and to give an appearance of solidity to pure wind.

—George Orwell, “Politics and the English Language”

You can't substitute Government concern for parental love.

—Paul Gianelli, an attorney for the parents of Baby Jane Doe, on learning that a Federal judge had denied the Government access to the baby's medical records.

*If we compare a severely defective human infant with a nonhuman animal, a dog or a pig, for example, we will often find the nonhuman to have superior capacities, both actual and potential, for rationality; self-consciousness, communication, and anything else that can plausibly be considered morally significant. Only the fact that the defective infant is a member of the species *homo sapiens* leads it to be treated differently from the dog or pig.*

—Prof. Peter Singer, bioethicist, “Sanctity of Life or Quality of Life?” July, 1983, *Pediatrics*, the official journal of the American Academy of Pediatrics.

If it becomes accepted practice to terminate a severely handicapped infant's life, where will the line be drawn—multi-handicapped babies? blind babies? potentially learning disabled babies? blue-eyed babies?

—Alan Berger, a developmental disabilities specialist, Flower Fifth Avenue Hospital, N.Y., letter to the *New York Times*, November 13, 1983

This a series on the politics of death. Beginning with infanticide. I don't know yet where we're going to end, but I will certainly have the very bad taste to include certain illuminations from Adolf Hitler's practices in these matters. Like this observation by Yale Kamisar in his all too prescient essay, “Some Non-Religious Views Against Proposed ‘Mercy Killing’ Legislation,” in the May 1958 *Minnesota Law Review*:

“ . . . while public resistance caused Hitler to yield on the adult

euthanasia front, the killing of malformed and idiot children continued unhindered to the end of the war, the definition of children expanding all the while.”

A footnote in the same essay reveals that among the factors that encouraged Hitler, early on, to try to push euthanasia were certain petitions to him by “parents of malformed ‘children’ requesting authority for ‘mercy deaths.’”

Yale Kamisar, professor of law at Michigan State University Law School, is one of the nation’s preeminent defenders of the Bill of Rights. He is perhaps best known as the leading expert on the Fourth Amendment, but Kamisar is an authority on a hell of a lot more besides. Significantly, he is one of the few civil libertarians in the nation who has explored the legal and moral problems in the killing, for example, of infants born with Down’s Syndrome.

As we shall see, the American Civil Liberties Union is of no use at all in these cases—to the baby.

Anyway, there will be more from Kamisar as we go on, and the first detailed examination of an actual case will be that of an infant who, last year, in Bloomington, Indiana, was allowed by his parents and doctors to starve to death because he was born with Down’s Syndrome. Or, as George Will put it in his column at the time, “The baby was killed because it was retarded.”

First, however, an explanation of why I am taking this journey into the minefields of who should decide who shall live and who shall die. And what lines are to be drawn—and where.

The impetus came from Baby Jane Doe on Long Island—born with an opening in the spinal column (spina bifida): a defect in the formation of the brain stem that causes a buildup of fluid on the brain; and an abnormally small head and brain. With her parents refusing to allow corrective spinal surgery for their daughter, just about the only folks battling to get Baby Jane a longer life span were the usually Yahoos, as enlightened liberals like to think of them: the Right-to-Lifers and such columnists as George Will and Patrick Buchanan.

Oh, in letters-to-the-editor and on radio talk shows, there were some parents of children with spina bifida and other severe defects who practically begged Baby Jane’s parents to get the surgery performed before more harm was done. Their spina bifida kids were not growing up perfect, but these parents sure were glad the kids were around.

A journalistic aside here. In most newspapers and magazines—*Newsday* being a notable exception—the reporting on Baby Jane’s alleged future has been lazy and ignorant. Most reporters have kept copying from each other the worst-possible-case-prognosis—if the baby’s life were to be extended, she would be in constant pain, would have no awareness of her environment, would be wholly

bedridden, and would be altogether inferior to Professor Peter Singer's more morally significant dog or pig (in the epigraph at the top of this column.)

It ain't necessarily so. There was, for instance, disagreement among the doctors at University Hospital in Stony Brook, where Baby Jane Doe is in residence. Not even specialists in this field have the gift of certain prophecy.

Dr. Albert Butler, Chairman of the Department of Neurosurgery at University Hospital was interviewed by B.D. Colen in the November 9 *Newsday*. By contrast with the unrelievedly mechanical reporting in other publications about Baby Jane's dismal future, this *Newsday* story quoted Dr. Butler as one who "favors surgery in cases *medically identical* to those of Baby Jane because he believes such infants have far more potential than other Stony Brook physicians have predicted for the patient." (Emphasis added.)

Dr. Butler has treated some 350 children afflicted with spina bifida. And he has seen Baby Jane Doe's records.

Butler wasn't making any flat predictions. But, he said, in cases similar to that of Baby Jane Doe—he couldn't ethically talk about her case specifically—you might have "a child who with special education could be able to feed himself, talk some, have fun in a very rudimentary kindergarten-type class but not necessarily go home with much information. Certainly there would be little expectation of pain."

Nonetheless, said Dr. Butler, while he would present all the options to the parents of such a child, he would never try to force them to consent to surgery, and he is opposed to any Federal intervention in such cases.

Who would not agree that it should be entirely up to the parents? Well, the Right-to-Lifers, George Will, Patrick Buchanan, Joseph Sobran. And me. Infants are not chattel. On the other hand—as will be detailed later in this series—the state has an obligation to provide the parents of these children all necessary financial support, indefinitely, once a handicapped life has been saved.

Let me concede my species loyalty in front. I do believe that humans are more worth saving than dogs or pigs. Justifying that, as an atheist, may present some difficulties, but we'll get to them. As for now, in this particular case, there is a baby who *might*—and unlike "objective" reporters on the other side, I won't go beyond *might*—have some fun and learn a few things if she were allowed to live beyond the two years expected to be her life span without surgery.

As a person under the Constitution, has Baby Jane Doe no rights of her own to live as long as she can? No due-process rights? No rights to equal protection under the law? Or, let me ask a question of you that the Supreme Court of the United States was recently urged to answer. It was brought by Infant Doe of Bloomington, Indiana who was sepulchraly asking the Court to review, under

the Constitution, the process by which he had been allowed by his parents and doctors to starve to death because he was retarded:

“Does a newborn handicapped infant have rights of his own or do parents have a right of privacy that transcends his rights and allows them to determine whether he will live or die?”

The Supreme Court, without comment, waived the question away. It was moot. Because the baby was moot.

But Baby Jane Doe is still alive. Not yet moot. Do her parents indeed have exclusive rights over her life? Has *she* none at all?

While these principles are being debated, who can rescue her right now?

Not the Feds, God save us! Even if all they want to do is look at her medical records to see what’s going on. In editorials, the *New York Times* (“Baby Jane’s Big Brothers”) and the *Wall Street Journal* (“Big Brother Doe”), excoriated prying Big Government, but had no comfort for Baby Jane. Her life, even after surgery, would hardly be a life, said the *Times*. Weep for “her tormented parents.” And let the kid die. “Baby Jane, everyone agreed, is not going to get better.”

Everyone?

Listen, said the *Wall Street Journal*, there are going to be a lot more cases like this because advancing medical technology is forcing us to make decisions about death “where formerly nature took its course.” You remember Nature? He also used to go by the name of Thomas Hobbes.

So what are we to do? “The inevitable agony,” says the *Wall Street Journal*, will be much less if these decisions, and *any mistakes*, are left to the families involved; most often the families will decide on the basis of love, and, in any event, it is the family that must live with the resulting burden of guilt.” (emphasis added.)

A “mistake,” as I understand it in this delicate context, is a corpse who ought not to have been a corpse.

And what about those families who do *not* decide “on the basis of love?” Some are cold, some are brutish, some are unswervingly utilitarian. Well, if parents without love make a mistake or two, the justice of the *Wall Street Journal* will be vested upon them: they’ll have the blues in the night. Yet, hasn’t someone been left out in all these homilies? Ah, that’s assuming you believe babies have rights independently of their parents.

As the editorials and the reporting on this issue indicate, we shall find during this journey luxuriant growths of newspeak. For instance, the liberal and civil libertarians—except for Yale Kamisar and a few others—will never speak of killing inconvenient babies. Their much more refined way of putting it is: letting infants die.

Or consider a phrase much circulated during all the coverage on Baby Jane Doe: “conservative treatment.” The parents would not allow surgery, and instead the baby is getting “conservative treatment.” At first, reporters ascribed the phrase to the doctors and the parents, but soon began to use it on their own as if it were, in terms of this child, an honest part of the English language. As in Marcia Chambers’s New York *Times* story:

“Under the conservative treatment the parents have chosen, [Baby Jane Doe] could live up to two years. With surgery she could live up to 20 years.”

You get the picture? The “radical treatment” is to give the baby 18 years more of life. The other approach is to kill her in two years. But “conservative treatment” sounds so proper, so responsible, that most readers will certainly agree that Baby Jane Doe is in the best possible hands. It’s something like the only President we’ve got calling the MX missile “The Peacekeeper.”

One man not given to euphemism in these concerns is Dr. Joseph Fletcher, a theologian and medical ethicist, who has long been a no-nonsense advocate of euthanasia:

“It is naive and superficial to suppose that because we don’t do anything positively to hasten a patient’s death, we have thereby avoided complicity in his death. Not doing anything is doing something.”

Meanwhile, as for Baby Jane Doe, until a shunt is permanently implanted to drain the buildup of fluid from her brain, the pressure on her brain will increase and more damage will be inflicted. And the longer her spinal surgery is delayed, the less chance she will have for a reasonable existence. And eventually, the New York *Times* will have been proved right. Baby Jane Doe will not get better. Baby Jane Doe will be moot.

The Baby Who Was Starved to Death for His Own Good

I went into medicine to do two things: to save lives and alleviate suffering. But I do not interpret that to mean that I will alleviate the suffering of my patient by disposing of my patient.

—Dr. C. Everett Koop, United States Surgeon General
Face the Nation, CBS-TV, November 6, 1983

Who do they think they are—asking me to help them commit infanticide?

—Linda McCabe, an RN in the special care nursery, Bloomington Hospital, Bloomington, Indiana, April 1982

Prologue to the short, unhappy life of the Bloomington Baby: In 1976, the American Academy of Pediatrics awarded its highest honor to C. Everett Koop, a pediatric surgeon of international renown. In his acceptance speech, Koop, a truthful man, said: “You all know that infanticide is being practiced right *now* in this country, and I guess the thing that saddens me most about *that* is that it is being practiced for that very segment of our profession which has always stood in the role of advocate for the lives of children.”

No one can be sure how often nature is allowed to take its course—to use one of the many handy euphemisms in neonatal intensive care units. It’s a very quiet affair. As one team of researchers puts it, the decision to let the baby go is “couched in professional confidentiality between physicians and parents. Unless individual cases present legal challenges or attract media attention, we can know little of the extent or the details of the practice.” (“Treatment or Involuntary euthanasia for Severely Handicapped Newborns: Issues of Philosophy and Public Policy,” *The Journal of the Association for the Severely Handicapped*. Winter 1982)

Going through the literature on this subject, however, I found that one thing is certain: there is a decided increase in the withholding of life-sustaining treatment for severely handicapped infants. And within the medical profession, this practice is becoming more and more acceptable. Life itself is of less importance than the quality of that life as the doctors in attendance foresee it. (God bless the child that’s got all its parts working.)

With this survival-of-the-fittest value system in the ascendant again, it’s hardly surprising that rather urgent articles on this subject are appearing in such publications as *The Journal of the Association of the Severely Handicapped*.

If we are to have a brave new world of perfect babies—with parents having a second chance at aborting infants who are born defective—then do we really want the landscape cluttered with badly handicapped adults who cost more than they can produce? And who are aesthetically displeasing besides.

I should note that there are doctors and nurses who are appalled at what the current growth of infanticide portends concerning the brutalization of this society sooner rather than later. Not that they themselves would strive mightily to save *every* infant life. There are babies, they point out, for whom heroic measures make no sense, for they will die no matter what you do. Certain very premature babies, for example. And some babies are born dying, some without brains.

But the concern of these doctors and nurses—and the locus of this series—is handicapped infants whose future is open. They may not grow up to be Ronald Reagan, but they have a chance at life that could be meaningful to them. Yet a good many such infants are disposed of without review by a court, by a hospital ethics committee, by anybody.

How many babies of all kinds are helped to “pass on”? Again, nobody knows for sure because it’s not all writ down on the records the way it really happened. But B.D. Colen, an exceptionally careful medical writer for *Newsday*, estimates that “the decision to withhold or withdraw treatment from extremely sick, premature, and/or deformed newborns is probably being made at least once every day by anguished parents and doctors in one of the nation’s more than 500 intensive care nurseries.”

Some of the doctors, as we shall see, are less anguished than others. But some do have disquieting moments. B.D. Colen tells of a specialist in the treatment of the newborn who says: “I have a recurring dream every so often. I’ve died and I’m going to Heaven, and as I go through the gates, I see what looks like this field of gently waving grass. When I look closely, it’s babies, slowly undulating back and forth—the babies I’ve shut off.”

Linda McCabe, a nurse with considerable experience in caring for infants who need special attention, works at Bloomington Hospital in Bloomington, Indiana. During the second week of April last year, she was driving to her job and was suddenly confronted by a march that was moving from the front of the courthouse to the hospital. The demonstrators were Right-to-Lifers, and among the signs they carried was one that called Bloomington Hospital “the new death camp.”

Linda McCabe was furious. Not at the marchers, but at the hospital, which had not made it at all clear to the public that what was going on inside—the starving to death of a Down’s Syndrome baby by agreement between the parents and certain doctors—had nothing to do with the nurses after a certain point. McCabe and her colleagues in the special-care nursery had refused to be part of the killing. Private nurses were imported instead. Not everybody is that finicky about these things.

“I was horrified having to drive through those signs,” Linda McCabe told me recently. “I couldn’t believe those people were blaming *me*. While it was in my care, I was doing everything I knew how to do to save that baby.” (She also wants to emphasize that the hospital administration *was* consistently supportive of the decision by her and the other regular nurses not to be accomplices in the baby’s death.)

Baby Doe was born on April 9, 1982, with two problems. One was correctable—a deformed esophagus which prevented food from reaching his stomach. But the infant *could* be fed intravenously until the blockage was surgically corrected. The operation is not a routine process, but the probable success rate of such

an operation is better than 90 percent. The sooner the operation the better the success rate.

The infant had one other problem, and that was not correctable. This was a Down's Syndrome baby. He would be retarded.

Down's Syndrome occurs once in every 700 births. It used to be called "Mongolism" because, as Dr. Anne Bannon, former head of Pediatrics at St. Louis Hospital, points out, "the fold of skin at the inner corners of the child's eyes causes a slight upward slant, giving a quasi-Oriental look to the child's face. And the baby's face may appear to be flat, with a flat-bridged and short nose."

The degree of retardation of Down's Syndrome children varies. Their IQs can range from 30 to over 70. ("Normal" IQ is from 80 to 120.) Many are not severely retarded.

Many respond well when there is early intervention to stimulate their mental capacities. They tend to be happy children, often the joy of a family. At least the kind of family that lets them live.

Many Down's Syndrome children grow up to get jobs. And if they can't work comfortably on the outside, they function in sheltered workshops. Furthermore, there are some who, with love and patience and instruction by one or more members of the family, can exceed expectations by quite a lot. One such kid, having shared a room with his older brother, who kept teaching him things, recently entered high school.

In terms of a Down's Syndrome *infant*, the most important thing to keep in mind is the last sentence of the report on "Baby Doe"—the Bloomington baby—in the September 15, 1983, *New England Journal of Medicine* by Dr. John Pless, the county coroner who performed the autopsy on this baby who was sentenced to be starved to death.

"The potential for mental function and social integration of the child, as of all infants with Down's Syndrome, is unknown."

Neither at the time the Bloomington Baby was born nor at the time he died six days later was it possible to predict how retarded he would be. Yet, his parents and their doctor refused him food and water—and they refused to allow the operation that would have enabled him to live. And so, as Dr. Anne Bannon notes in the Fall 1982 *Human Life Review*: "He died slowly and painfully while many doctors and nurses stood by, watched, and did nothing. But there were some who tried."

Before I get to those who tried, in addition to Linda McCabe and the other regular nurses, it's worth noting that this was not an infanticide hidden behind the screen of doctor-patient confidentiality. The case was widely publicized, although certain of the details you'll be reading next week were not available at

the time, having been sealed by court order.

Furthermore, Baby Doe's future was weighed by the courts of Indiana, and his case even went to the Supreme Court of the United States—though by then Baby Doe could only watch, with bemused interest, from Heaven.

All the proper procedures—as defined by the good liberals and the good civil libertarians, supporting the parents in this year's Baby Jane Doe case on Long Island—were taken in Bloomington. Parental wishes were given high priority; at least some doctors agreed with the parents, the courts were involved and they agreed with the parents. What more could any humane civil libertarian want?

Why, even when some people wanted to adopt Baby Doe—Down's Syndrome and all—the baby was saved from those strangers who would have saved him. Better he should spend his last hours with those who loved him.

The point here is that this system won't do. There has got to be a way in which babies are not starved to death because they're retarded. Or are otherwise "shut off" because they have other handicaps that make them a lot less than perfect. By the end of this series, I shall report on a number of ways that are being proposed to monitor these decisions.

On the other hand, as will be evident in future columns, there is a growing school of doctors and bioethicists who believe it is time—as *California Medicine* has put it—we abandon our sentimental attachment to the "long held Western ethic of intrinsic and equal value for every life ... It will become necessary and acceptable to place relative rather than absolute values on such things as human lives ..." (Editorial, *California Medicine*, official journal of the California Medical Association, September 1970)

Some lives just ain't worth society's trouble to keep them going.

For instance, in *Deciding to Forego Life-Sustaining Treatment*, a March 1983 report by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, there is this cold augury of the future purification of our species:

"When California pediatricians were polled in 1975 about how they would treat a Down's Syndrome baby with a life-threatening intestinal obstruction (assuming parental agreement and immunity from existing laws), 17 percent said they would do 'everything humanly possible' to save the baby's life, while 61 percent would give ordinary medical care but 'nothing heroic' (meaning the baby would die without the operation to remove the obstruction) ... [Another] study found that 51 percent of the pediatricians surveyed in Massachusetts would not [even] recommend surgery for a Down's Syndrome infant with intestinal blockage."

It is a more than safe assumption that the vast majority of those doctors would operate to remove the obstruction if the baby were “normal.”

“Ever since that baby was killed at the hospital where I work,” Linda McCabe told me, “I have talked about what happened every time I get the chance. It’s all I can think of that I can do. People have to know. So I don’t mind your using my name at all.”

Next week: More on Linda McCabe. And exactly how the decision was reached—by all the responsible, caring parties—to starve Baby Doe to death for his own good. Yes indeed.

“He was hungry. He cried. He moved. He was one of us.”

As to the exposure of children, let there be a law that no deformed child shall live.

—Aristotle, *Politics*, VII

Nature has its laws and we should observe them. Maybe we shouldn’t try to rescue those whom nature or God has created so imperfectly.

—Dr. Raymond Duff, professor of pediatrics, Yale University, *Herald-Telephone*, Bloomington, Indiana, April 16, 1982

I’m a little cookie, yes, I am. I was made by the cookie man. On my way from the cookie pan, A little piece broke off-a me. Now I ain’t as round as I might be. But I’ll taste good, just wait and see. And I can love back just twice as hard As any regular cookie can.

—Larry Penn, A Milwaukee truck driver, composer, and singer. From “I’m a Little Cookie.”

Let us begin at the end of Baby Doe’s week of life in Bloomington, Indiana, in April 1982. The baby had been born on April 6 with two defects. One, a malformed esophagus, required surgery so that food could reach his stomach. It is an operation with more than a 90 percent success rate. The other thing wrong was that the baby had Down’s Syndrome. He would be retarded.

After listening to their obstetrician, Baby Doe’s parents decided they did not want to bring up this child. There would be no operation to correct the malformed esophagus. There would be no intravenous feeding. The infant would get no sustenance at all. As one lawyer who advised the parents told me, “The decision was made to let the infant die.”

“You mean the decision was made to kill the infant.”

“That,” said the angry lawyer, “is a loaded word.”

You betcha. Killing is a word for street crime, not for what decent people do for the good of the victim. When the Bloomington Baby died, the headline in the Washington *Post* was: “The Demise of Infant Doe.” That’s how a well-bred person would put it.

But in the Washington *Post* column, George Will, father of a much-loved Down’s Syndrome boy, said: “‘Demise’ indeed. That suggests an event unplanned, even perhaps unexplained. (The demise of Abraham Lincoln?)”

One of the doctors at Bloomington Hospital had tried to prevent the “demise” of Baby Doe from the day he was born. Pediatrician James Shaffer, who had been called in to examine the baby but whose advice had been rejected by the parents, became a forceful advocate of the infant. With the hospital administrators. With the courts. But nothing worked. And the baby was starving to death.

On the sixth day, Shaffer couldn’t stand it any more. In the Fall 1982 *Human Life Review*, Dr. Anne Bannon, formerly head of pediatrics at St. Louis Hospital, tells what happened then.

“... he (and two other pediatricians) went with intravenous fluid in hand to the private room on an ‘adult’ floor (where the baby and his hired private-duty nurses were sent when the Nursery nurses refused to starve the baby). It was the first time in several days that Dr. Shaffer had seen the infant. It was also the last time.

“He did not start the fluids. But he described for me what he saw in that adult room on that floor in a modern hospital in the richest country in the world. Baby Doe’s shrunken, thin little body, with dry cyanotic skin, extremely dehydrated, breathing shallowly and irregularly, lay passively on fresh hospital linens. Blood was running from a mouth too dry to close ... Too late for fluids. Too late for surgery. Too late for justice.”

The Washington *Post* observed: “The Indiana baby died not because he couldn’t sustain life without a million dollars worth of medical machinery, but because no one had fed him.”

And Stephen Chapman noted in the Chicago *Tribune*:

“The eagerness of so many couples to adopt Baby Doe offers a vision of what we might be. But the death sentence given him by our duly ordained courts offers a glimpse of what we are becoming.”

What *are* we becoming? Polls indicate a decisive majority of the citizenry support the parents' decision in Long Island this year to give Baby Jane Doe "conservative treatment." (That is, to greatly speed her "demise.") And increasingly, doctors instruct us that "quality of life" is the name of the survival game as medical technology makes it more and more possible, and costly, to preserve life. If you're just going to be a drag, who needs you? But who decides whether someone's life is worth saving by that rather slippery criterion? Why, the doctors will decide. As law professor Yale Kamisar reports one eminent doctor as saying: "Look, do the passengers tell the pilot how to land the airplane? So relax, and leave the dying to us."

Other doctors, more sensitive to the politics of death, prefer that more hospitals set up ethics committees to decide who shall live and who shall die. (For one thing, it's harder to sue a committee.) These review committees would include not only doctors but other kinds of specialists, and even some token lay people.

Then there is the rapidly emerging new priesthood of bioethicists. No hospital review committee will be kosher without one. They are the multidisciplinarians of death. And occasionally, I hope, of life. But somehow I get the feeling, reading some of them and watching them on television, that I don't want a bioethicist on my case. But as time goes by, will I have a choice?

The case of the Bloomington Baby—and a companion earlier killing, that of the Johns Hopkins Baby (who had the bad grace to take 15 days to starve to death)—can serve as an introduction to what kind of people we're becoming. And what we can do about it. If we want to do anything about it.

How were the decisions which continually condemned the Bloomington Baby to death arrived at? Why did the parents and the courts act as they did? Are new laws needed? Indiana has one now, as a kind of epitaph for Baby Doe. Will it prevent similar killings? Do we need a new law in New York to protect future Baby Jane Does? Is there any place in all of this for the Federal Government, which has suddenly become Orwell's monstrous Big Brother to those very same liberals who urge the Feds to subpoena all records imaginable in cases of racial and sexual discrimination?

We will also examine what "informed parental consent" actually means in these life-or-death situations. And we'll look at the role of the press. I do not believe that so many citizens would have voted thumbs down in the matter of Long Island's Baby Jane Doe if more reporters had done more independent investigating of both the medical facts in that specific case and the actual states of body and mind of those spina bifida children around the country who have not been killed off.

Now to start at the beginning. When the Bloomington Baby was born, the

parents' family doctor asked Dr. James Shaffer, a pediatrician, to examine the infant. Shaffer diagnosed the malformed esophagus and the presence of Down's Syndrome. Like the majority of the hospital staff, Shaffer strongly felt corrective surgery of the esophagus should take place so that the baby would live. But the family's obstetrician, Dr. Walter Owens, had already spoken to the parents. He offered them the alternative of doing nothing to save the life of the child.

Why? Because it was a Down's Syndrome child. At a court hearing during the brief life of Baby Doe, Dr. Owens testified that even if the surgery to correct the malformed esophagus were successful, "This would still not be a normal child. Some of these [Down's Syndrome] children . . . are mere blobs . . . Most of them eventually learn to walk and most of them eventually learn to talk . . . This talk consists of a single word or something of this sort at best. These children are quite incapable of telling us what they feel, and what they sense, and so on." This baby, Dr. Owens concluded, could not attain "a minimally acceptable quality of life."

There's that killer phrase again—"quality of life."

In rebuttal, Dr. James Laughlin, a pediatrician, testified that at this stage of the infant's life, it was impossible to determine the degree to which he would be retarded. Furthermore, Laughlin pointed out that Down's Syndrome kids have a broad range of IQs, some going into the normal intelligence range.

I have no idea why Dr. Owens, the obstetrician, was so spectacularly uninformed about Down's syndrome children, but his was the dismal prophecy that persuaded the parents. Maybe, had there been a biomedical ethics review committee at Bloomington Hospital in April 1982, Dr. Owens's decision would have been reversed by the members of the panel who knew, among other things, that Down's Syndrome kids can say more than just one word. And that to call them "blobs" tells us more about the good doctor than about these children.

But what about the parents? Would they have been convinced? At the same hearing at which Owens testified, the father of Baby Doe said that he and his wife had "determined that it is in the best interest of the Infant Doe and the two [normal] children who are at home and their family entity as a whole" that the child should be left to die.

There, it seems to me, is a clear and fatal conflict of interest between these parents and this baby. The parents were representing their own interests, as they saw them. The baby's interests were, to say the least, counter to theirs. He needed, and very quickly indeed, to be treated both for his malformed esophagus and for the denial of his right to remain a person under the Constitution.

But although his parents had, in effect, abandoned him, Baby Doe was not alone. Dr. Shaffer was fighting for the infant's life. So were two county prosecutors, a law professor, and nurses at Bloomington Hospital. One of the nurses,

Linda McCabe, told me, “A lot of us started looking up legal arguments ourselves. And we found some cases in which the court decided for the baby, not the parents. So we thought Baby Doe would win.”

Instead, the judges kept affirming the sentence of death imposed on the baby by his parents. As when, on the afternoon of the night the infant died, Circuit Judge Pro-Tem Thomas Spencer ruled for the second time (as reported in the *Bloomington Herald-Telephone*) “that there was no probable cause to believe that the baby had been neglected by his parents and thus should be taken from their custody.”

If starving a baby to death is not neglect, then what the hell is?

Some weeks later, about 75 members of various right-to-life groups conducted a memorial march in Bloomington for Baby Doe. Nobody else came. No liberals, no civil libertarians. Hell, they wouldn't be caught dead marching alongside such intellectual inferiors.

The marchers were singing, “All we are saying is give life a chance.” And one of them said to a reporter about the dead baby:

“He was hungry. He was thirsty. He cried. He moved. He was one of us.”

Well, if he was one of us, why did all the judges say he had to leave?

Sticks and Stones Break Baby's Bones but Words Kill

“If we're going to have legalized euthanasia in this country, it's going to begin in the nursery.”

—Dennis Horan, A Chicago attorney and medical ethics expert for the American Bar Association, March 1983

“If a child were not declared alive until three days after birth, then all parents could be allowed the choice only a few are given under the present system. The doctor could allow the child to die if the parents so choose, and save a lot of misery and suffering. I believe this view is the only rational, compassionate attitude to have.

—Nobel laureate James Watson (of DNA double helix renown), May 1973

“One must decide for whose benefit is the decision to withhold treatment from a child with severe defects. Is no life better than one of low quality? The person to ask is an individual who has a disabling birth defect.”

—Dr. John Robertson, then of the University of Wisconsin Law School and Medical School, 1975

“The night before little Infant Doe died [in Bloomington], I called the Indiana Supreme Court and told them I wanted the baby saved. I am a Down’s Syndrome child and I want the baby boy saved’.”

—Sherry McDonald, Letter to the Evansville, Indiana *Courier*, April 17, 1982

Death in the Nursery, a four-part investigative report by WNEV-TV in Boston, was shown in New England in February and March of this year. No television documentary by any of the network news organizations during 1983 came close to equalling the power—indeed, the shock—of this local news team’s exploration of infanticide in hospitals around the nation. (There should be a weekly or monthly TV forum, through cable, so that all of us in all the provinces can see the best television journalism from Boston, Chicago, Houston, et al.)

Having examined thousands of death certificates and interviewed many doctors and parents in some 20 states, the Boston reporters discovered that there’s a hell of a lot of infanticide going on. That is, the withholding of lifesaving medical care from variously imperfect babies, including a good many spina bifida and Down’s Syndrome newborns. One case in that television series should be of particular interest to those who are pragmatically against capital punishment—what if it’s the wrong man?—but do believe parents have the right to dispose of damaged babies when doctors predict for them a poor “quality of life.”

In part four of *Death in the Nursery*, reporter Mike Taibbi tells of a case “where a premature infant was allowed to die . . . at the urging of a neurosurgeon who mistakenly diagnosed anencephaly . . . the absence of a brain . . . An autopsy showed there was a brain . . . which had the characteristics of prematurity but which was perfectly formed.”

There was considerable reaction to the television series, much of it horrified. A viewer in Vermont wrote to the *St. Alban’s Daily Messenger* of being stunned that this was going on “not far away in some remote Red China province, but here, in the land of the free—in some of our most prestigious teaching hospitals!”

Most doctors practicing infanticide wish the cameras and reporters would not meddle in things they do not understand, thereby stirring up those of the laity who also do not yet understand that the value of human life is relative. And the parents involved certainly don’t want any attention. That’s why the common surname of the victims is Doe.

The parents cannot even bring themselves to say what it is they’re doing.

Baby Jane Doe, for instance, is getting “conservative treatment.” In 1970, when the “Johns Hopkins Baby,” a Down’s Syndrome child, was taking forever to starve to death at the medical center, the father, who had ordered the denial of food and water, would call up the doctor and say, “How are things?”

“He meant,” the doctor recalls, “‘Is the kid still alive?’ I felt uncomfortable talking to him, and I felt a little funny saying, ‘Things are working out, they’re just taking a little slower’.”

Many nurses avoid talking about their part in the deathwatch. Many do not like the assignment at all; some refuse it. And a few do speak out. For instance, Linda McCabe of Bloomington, Indiana, in the last two columns here. Others, without telling their doctors, sneak in a bit of life. Like the nurse in Phoenix, quoted anonymously in *Death in the Nursery*: “I just can’t take it. I know we are not supposed to feed the baby, but I take my finger and put it in a glass of water and drop the water on her lips because they are so dry.”

If we are ever to have a perfect race, we must do something about these sentimentalists.

A key element in keeping most of these infanticides invisible is that the law winks at them. In the just published *The Rights of the Critically Ill* (An ACLU Handbook, Bantam), Professor John A. Robertson notes that parents and doctors could be prosecuted for denying essential treatments to infants with congenital defects such as Down’s Syndrome “with the intent and result that they die.” Why? Because “failure to provide necessary medical care would constitute child abuse or neglect.” And when the child dies, the parents can be charged with murder or manslaughter. However, there has only been one (1) prosecution of parents and doctors “for nontreatment of defective newborns.” And in that case, charges were dismissed “at a preliminary hearing when no one testified that the parents and doctors actually ordered starvation.”

With little to fear from the law, and convinced that infanticide is truly in everybody’s best interest, doctors and parents, in growing numbers, elect this course of “treatment.” The only things that invade their privacy are the occasional cries and alarms accompanying the sudden public discovery of a deliberate killing in the nursery.

If the revulsion to these public deaths is strong and durable enough, a state legislature may change its laws to better protect future imperfect babies. (As Indiana has because of the killing by starvation of Baby Doe.) And conservative members of Congress may speak indignantly into the *Congressional Record* as they introduce Federal legislation. (But why do no liberals like Ted Weiss or Pat Schroeder ever speak for the Baby Does?)

And it is because of such cases as those of Baby Doe and Baby Jane Doe that

the American Civil Liberties Union has, at last, appointed a committee to review the ACLU's policies on euthanasia in general, along with such particulars as who should speak for the defective baby as its parents and doctors begin to give it that good-bye look. "We'll be examining euthanasia from the grave to the cradle," an ACLU official told me. Well, once logic takes hold of the committee, it's going to be difficult for its members to stop at the cradle. Because of accelerating medical advances, the fetus is becoming viable at an earlier and earlier stage. Eventually, not only the ACLU but the Supreme Court too will have to take another look at its life-or-death rules on these matters.

While the ACLU committee performs its labor, I intend to suggest, among other things, some changes in the law to make infanticide a lot less easy. Two of them come from what we learned in the case of the Bloomington Baby.

He was born on Friday, April 9, 1982, and the hospital administration, on being told that the infant's parents and their obstetrician wanted him starved to death, moved to get a judicial opinion. After all, the killing was going to take place right there. The baby had a malformed esophagus which could have been repaired by surgery, but since this was a Down's Syndrome baby, the parents decided to deny him surgery, and also food and water.

Late Saturday evening, April 10, Superior Court Judge John G. Baker held an emergency hearing at the hospital. Since the rights of a minor were at issue, Baker should have first appointed a guardian ad litem (an independent advocate and protector of the child's interests who would also develop a factual record on behalf of the baby). Under Indiana law, Judge Baker was not compelled to immediately appoint a guardian ad litem, nor would he have had to in many other states in which the law is similarly defective.

The judge, therefore, became the "protector" of the child, and in his awesome wisdom, after hearing from those who would kill the baby and those who would save him, Baker ruled that he would allow the parents to choose the course of "treatment" for the infant suggested by their obstetrician, Dr. Walter Owens. The "treatment" was *no treatment*. No operation. No food. No water.

At that stage, the judge did appoint a guardian ad litem for the baby. He had, after all, administered a sentence of death and for the sake of proper appearance, there ought to be someone to bring an appeal for the kid on death row. Judge Baker selected the Monroe County Welfare Department's child protection team.

First of all, these worthies did not get themselves together for a meeting on what to do next until the following Monday night, April 12. The baby, meanwhile, was starving right along. And then, missing the judge's message—he hadn't thought it was good court etiquette to tell them outright to appeal his decision—the child protection team decided *not* to appeal on behalf of the baby.

To this day, the child protection (*sic*) team has refused all public comment

on their reasons for not appealing the sentence of death. They wouldn't even tell the Department of Justice. (Protecting their own privacy?)

So, Rule One: at the moment when a decision is taken by the parents and the doctors to "let the child go," that decision must be made known to the courts so that a true *guardian ad litem* will be appointed for the infant. I will leave for later the criteria by which these guardians will be selected and what their powers will be in this context. (Advice from readers, lawyers included, will be welcome.)

Rule Two: No guardian ad litem, let alone a goddam so-called "child protection team" can be allowed to keep to themselves the reasons for whatever decisions they make.

I will spare you the tumultuous parade of additional guardian ad litem and judges who danced their minuets in the little time the baby had left. But I cannot omit a hearing, five hours before the Bloomington Baby died on Thursday, April 15. The judge was John Baker again, and appearing before him was attorney James Bopp, representing Bobby and Shirley Wright, parents of a three-year-old daughter with Down's Syndrome. They wanted to adopt Baby Doe.

"To save the baby's life," James Bopp told me, "it was necessary for the Wrights to be given temporary guardianship prior to adoption. That way they could get him fed before it was too late. I argued before the court that the baby had been neglected and abandoned. The parents' lawyer, though conceding that the baby was being given neither food nor water, claimed he had not been abandoned because the parents had come to see him a couple of times and were concerned for the welfare of the child.

"The parents' attorney also argued that the infant had not been neglected because the parents were following a course of treatment prescribed by a physician. To be sure, the treatment was no medical care, but it became medical care because it was prescribed by a physician. Therefore, the parents were not denying medical care to their baby. Finally, their lawyer argued, the baby was not in need of medical care, anyway, because he had a potential for mental retardation and therefore did not have sufficient quality of life to be preserved."

Judge Baker agreed with the attorney for the parents. The parents, he ruled, were not neglecting the child, and therefore had not abandoned it.

Leaving the courtroom, attorney James Bopp was shaking his head: "It's 1984. It's newspeak. It's peace is war."

At ten o'clock that night, Baby Doe gave up.

Troublemaking Babies and Pious Liberals

We cannot destroy life. We cannot regard the hydrocephalic child as a nonperson and accept the responsibility for disposing of it like a sick animal. If there are those in society who think this step would be good, let them work for a totalitarian form of government where, beginning with the infirm and the incompetent and ending with the intellectually dissident, nonpersons are disposed of day and night by those in power.

—Dr. J. Engelbert Dunphy, former president of the American College of Surgeons, during the annual oration before the Massachusetts Medical Society, 1976

. . . decisions to forgo therapy are part of everyday life in the neonatal intensive care unit; with rare exceptions, these choices have been made by parents and physicians without review by courts or any other body. This approach has been endorsed by the American Medical Association, whose Judicial Council holds [1982] that “the decision whether to exert maximal efforts to sustain life [of seriously deformed newborns] should be the choice of the parents.”

—“Deciding to Forgo Life-Sustaining Treatment,” a report by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, March, 1983

. . . no newborn infant should be declared human until it has passed tests regarding its genetic endowment and . . . if it fails these tests, it forfeits the right to live.

—Francis Crick, 1962 Nobel Laureate in physiology and medicine (This statement was made in January, 1978).

I personally feel that [Baby Jane Doe] does have the right to life, but the parents shouldn’t keep the baby because they don’t want her to have the operation. The baby should be adopted and taken care of by parents who want it and will love it. If the [natural] parents will be suffering while the baby is alive, they shouldn’t take care of it. Every life has a right to live.

—Julie Martinez, eighth grade, Ditmars Junior High School, Brooklyn

Richard Cohen is a columnist for the *Washington Post*. If commentators were rated by the groups that publish the batting averages of members of Congress, Cohen would get very high marks from Americans for Democratic Action, the American Civil Liberties Union, Ralph Nader's Public Citizen, and other cadres of liberalism. On this occasion, to his credit, Cohen writes against the grain of some of his customary constituents, as when he opposed Israel's invasion of Lebanon, thereby himself coming under prolonged bombardment.

He is much concerned with individual rights and liberties—except for those of certain handicapped infants. With regard to the killing by starvation of Baby Doe of Bloomington, Indiana, for instance, Cohen—in his sermonette on the demise of that infant—focused on “the quality of life that lay ahead” of the baby had it not been disposed of. “Its death might have been awful, but its life might have been worse.”

Mind you, as Cohen could easily have found out by using his telephone, the only thing wrong with that baby—aside from a routinely correctable malformed esophagus—was that he was a Down's Syndrome child. And there was *no way* of predicting, at so early a stage of that baby's life, how retarded he might have been. So Richard Cohen could not possibly have known what Baby Doe's “quality of life” would have been.

At the time, Cohen also sort of agonized about how difficult it is to decide whether to “take the life of an infant.” He came to the conclusion that “The only sure answer is, ‘It depends’—usually no, sometimes regrettably, yes. This is what the Indiana court said. As a result, two things died—a baby named Infant Doe, and a belief in absolutes. We have all grown up.”

Have we now? As has been shown here in detail during the past two weeks, the Indiana courts failed miserably to protect the independent rights of this infant—refusing even to let him be adopted, as the judges kept intoning that Baby Doe's parents were neither neglecting nor abandoning him by refusing to allow him to be given food and water. So, the only “thing” that died in this case was a baby who had every right to live.

A few weeks ago, in a conversation, Richard Cohen told me that maybe he hadn't thought hard enough about the Baby Doe case in Indiana. Okay, I figured, maybe he has grown up. Maybe he's not going to depend solely on what he sees on the wire services for his commentary on these cases. Maybe he's actually going to talk to some of the people involved.

Then, on November 29, came a Cohen column titled, like a headstone, *Baby Jane*. Once more, a fusillade of utterly confident prophecies by someone who has done no investigating of his own: “The real expectancy of her life is dismal at best.” “To prolong a life that would be barren of joy and, the doctors say, wracked with pain, is hardly ‘right.’”

But wait. Cohen is no cold fish. He is a liberal. Accordingly, he reminds us: “And neither is it ‘right’ to end that life by withholding surgical treatment that could extend it.”

So where does this leave Baby Jane Doe—strung between the horns of Cohen’s dilemma? Well you gotta go with the parents, says this bioethicist of the *Washington Post*. “Mr. and Mrs. Doe fight on,” writes Cohen, saluting them. But what Mr. and Mrs. Doe are fighting on to accomplish is the ending of this baby’s life. So which side is Cohen on? Well, he says he’s on the side of there being no “right” answers. Oh. So long, kid.

Now we come to testimony, before a New York State Supreme Court Justice, in the Baby Jane Doe case—testimony unreported in most of the press—which reveals, Richard Cohen notwithstanding, that there were no certainties as to the future of Baby Jane Doe if she had corrective surgery. No certainty of a life “barren of joy.” No certainty of constant pain. No certainty that she would be wholly bedridden. No certainty that she would never be able to meaningfully interact with her environment. No certainty of any of those other unqualified dismal predictions in so many news reports and editorials. Indeed, as some of the testimony shows, along with corollary analyses I’ve seen by doctors who are expert in spina bifida cases, the odds are the other way. For the baby.

For instance, Dr. David McLone, Chief of Pediatric Neurosurgery at Chicago’s Children’s Memorial Hospital—the national center for spina bifida surgery—said after looking at the testimony in this Baby Jane Doe court hearing: “*If you take our experience of a child [in Baby Jane Doe’s described medical condition] I would predict that the child in our hands would have normal intelligence and would be a community ambulator . . . [walking] probably with some bracing.*” (Emphasis added.)

The testimony I’m referring to can be found in the transcript of an October 19 hearing in Riverhead before New York State Supreme Court Justice Melvyn Tannenbaum. It’s a public document. If Richard Cohen had asked reporter Felicity Barringer of the *Washington Post*—who’s been doing unusually probing work on this story—she would have given him a copy, they being colleagues. But a column reads better, you know, with touches like “a life that would be barren of joy.”

In conflict at the Riverhead hearing were two physicians. Baby Jane Doe’s parents had been advised by their original doctor to go ahead with the surgery, but after talking to Dr. George Newman, a neurologist at Stony Brook Hospital, they changed their minds, and the first doctor withdrew. Newman’s view of Baby Jane Doe’s future was decidedly bleak. On the other hand, Dr. Albert Butler, chief of neurological surgery at the same hospital, who had treated some

350 spina bifida children, was in favor of surgery. Both Newman and Butler testified at Riverhead. And if there is to be a presumption for life in cases like this, the specifics in the conflict between Newman and Butler should have brought the state appellate courts, and the Federal District Court later on, to insist on Baby Jane Doe's right to equal treatment as a person under the Constitution. (What if, by the way, the parents had been Jehovah's Witnesses refusing certain vital medical treatment to their daughter?)

I expect you remember, for instance, how every single news account cited Baby Jane Doe's "abnormally small head." That's the way I described it, too. Well, at the Riverhead hearing, Dr. George Newman testified that the baby's head at birth was indeed "abnormally small," thereby giving her "virtually a 100 percent chance of being retarded."

But on the stand, Dr. Albert Butler said that the baby's head circumference of 31 centimeters was within normal measurements of a baby that size. (The hearing can be found as *The People of the State of New York, on relation of A. Lawrence Washburn ... against Stony Brook Hospital and the State University of New York at Stony Brook.*)

Worth noting is that the only judge who actually heard the conflicting medical testimony, who actually saw the doctors and other witnesses, ruled that Baby Jane was "in need of immediate surgical procedures to preserve her life." Justice Melvyn Tannenbaum, however, was reversed by the appellate division and the Court of Appeals.

All along, in all the battles through the courts, the only people trying to get Baby Jane Doe a better shot at life have been outsiders: A. Lawrence Washburn, who initiated the court proceedings, William Weber, appointed guardian ad litem because of Washburn's action, various Federal officials; and some advocates from right-to-life organizations.

They have been piously excoriated by editorial writers, among many other good citizens, as wanton intruders, cruel zealots, and well, outside agitators.

But who else was willing to try to get the kid a break?

A useless question, I suppose, if you believe—as Richard Cohen wrote of Baby Doe in Bloomington—that he was allowed to die for his "own good." I gather, from polls and from the mail I've been getting, most folks think if the lights were turned out for Baby Jane, it would be for her own good too. After all, what kind of life would she have? Why, everyone agrees she wouldn't be perfect.

It was on that score that Price Grisham wrote this letter to the *Washington Post* (December 11):

"Did the *Post* note the irony of running Richard Cohen's column on Baby [Jane] Doe in the same edition as the article on the National

Decade of the Disabled?

“Mr. Cohen refers to the baby’s life as one ‘barren of joy.’ When will people who are perfectly intelligent, clear-headed and well-educated stop assuming that one must be healthy, handsome, and preferably wealthy to be human and happy? I am not healthy (I have cerebral palsy), not handsome and as a [Federal] GS-5 clerk, will probably never be wealthy.

“My childhood and adolescence were spent in more than a decade of operations and therapy. Yet I am quite sane and quite firm when I state that I would not exchange my handicapped body for that of the most muscular Redskin player, for through it I have learned more in the 30 years of my life than some people learn in a century. I am not afraid to suffer, and I am not afraid to help those who now suffer.”

What happens, or does not happen, to handicapped newborns is related to how the handicapped who grow up are seen, or avoided, by the rest of us. It was logical, therefore, that when the Federal Government tried to get a look at Baby Jane Doe’s hospital records, an *amicus* brief was filed on the side of the Government—and, I would say, the baby—by the American Coalition of Citizens with Disabilities, the Association for Retarded Citizens, the Association for the Severely Handicapped, the Disability Rights Education and Defense Fund, Disabled in Action of Metropolitan New York, and the Disability Rights Union.

I bet you didn’t see that part of the story in the press. These groups came into Baby Jane Doe’s case because they sure know that people with disabilities are often discriminated against, even after they’ve escaped alive from the nursery. They see this as a civil rights case. Not a time for hand-wringing, but a time for organizing.

‘Did You Ever Get a Letter from a Vegetable?’

*And what rough beast, its hour come round at last,
Slouches toward Bethlehem to beborn?*

—”The Second Coming,” W.B. Yeats

At a recent convention of Catholic intellectuals, Morvan Lebesque said, “After centuries of morality, we still cannot answer questions like . . . Should malformed babies be killed? Where does man begin?” To which Father Jolif replied, “No one knows what man is any longer.”

—*Humanly Possible: A Biologist's Notes on the Future of Mankind*, Jean Rostand, Saturday Review Press, 1973

The whole history of medicine is at hand to answer any . . . death-doctor. Those who delivered humanity from plague and rabies were not those who burned the plague-stricken alive in their houses or suffocated rabid patients between two mattresses...Victory against Down's Syndrome—i.e., curing children of the ill-effect of their genic overdose—may not be too far off if only the disease is attacked, not the babies.

—Dr. Jerome Lejeune, discoverer of trisomy 21, the defective gene in Down's Syndrome, *The Lancet*, January 5, 1980

We're talking about people who, in the traditions of our culture and cultures throughout the world, have been left alone by natural law. That is, the argument has been—particularly, for example in Roman Catholic theology—that what nature or God has created extremely imperfectly should be left alone and go back to nature.

—Dr. Raymond Duff, Department of Pediatrics, Yale-New Haven Hospital, *CBS Morning News*, May 18, 1982

. . . at the intensive care nursery at Yale-New Haven Hospital . . . sometimes life-saving medicine or surgery is withheld. Other infants are allowed to starve to death. And in some cases, doctors at Yale-New Haven have helped parents give their defective infants lethal drug overdoses, two doctors there said.

—“Defective Newborns are Dying by Design,” Diane Brozek, Medical Writer, *Hartford Courant*, June 14, 1981

A startling article appeared in the October 25, 1973 issue of the *New England Journal of Medicine*. The information in it was not new to most physicians, and certainly not new to any doctor or nurse involved in the care of the newborn. What made the article so startling, however, was that this was the first time the information was being discussed openly. It was about death in the nursery. Death by design. This has been going on for centuries, of course—the swift disposal of defective infants. Sometimes the defect had been simply a matter of gender. No room in the family for another girl.

In a modern nation, however, it was bad form to talk about what went on behind those closed doors. Until that 1973 article, “Moral and Ethical Dilemmas in the

Special Care Nursery” by Dr. Raymond Duff and Dr. A.G.M. Campbell. The latter was a Scottish doctor; Duff was and still is an attending physician in the Department of Pediatrics at Yale-New Haven Hospital as well as a professor of pediatrics at Yale Medical School. The co-authors did not write the article to blow any whistles. The intent of their report was to show that in certain cases, death is a preferable “management option.” Which cases? Those in which the infants “were considered to have little or no hope of achieving meaningful ‘humanhood.’”

In every case in which a baby in their report had been ticketed for death, Duff and Campbell emphasized, the parents had been fully informed of all the options. And had given their consent to the death. (The problem with this kind of “informed consent,” when lay people are basing their decision on what specialists tell them, is that the temperament and experience of the specialist can make all the difference as to what the parents decide. A sanguine physician tells the parents about severely handicapped adults he knows who are full of “humanhood.” Another physician, who tends to see a glass as being half empty rather than half full, tells the parents about the institutionalized “vegetables” he knows who were needlessly and heedlessly saved at birth.)

The *New England Journal of Medicine* article focused on the deathwatch at the special-care nursery of the Yale-New Haven Hospital from January 1, 1970, through June 30, 1972. During that period there were 299 infant deaths in the nursery. Of them, 43—14 percent—were caused by the withholding of treatment by doctors and nurses. The babies chosen for death were variously defective. Among their ailments: cardio-pulmonary disease, central nervous system disorders, short-bowel syndrome, spinal malformations. Some of these conditions were untreatable, but some could have been treated. A case, for instance, of a Down’s Syndrome baby who also had an easily operable intestinal obstruction.

Why wasn’t the Down’s Syndrome infant treated for his intestinal obstruction? Because, Duff and Campbell explain, “his parents thought that surgery was wrong for their baby and themselves. He died seven days after birth.” Just like that. Just like the Johns Hopkins Baby with the same defect, except the latter took eight days longer to starve to death.

It’s up to the parents to decide, Dr. Duff keeps insisting. It’s their future; it’s their family that will be affected if the defective infant is brought home; and they’ll have to pay the bills. As for the infant, well, who knows better than the parents what’s in the best interests of the child?

In *Ethics at the Edge of Life* (Yale University Press 1978), Paul Ramsey is very skeptical of Duff’s insistence that “parents, facing the prospect of oppressive burdens of care, are capable of making the most morally sensible decisions about the needs and rights of defective newborns.” Says Ramsey:

“There is a Jewish teaching to the effect that only disinterested parties may, by even so innocuous a method as prayer, take any action which may lead to premature termination of life. Husband, children, family and those charged with the care of the patient may not pray for death.”

Duff and Campbell were also opposed by two of their colleagues. In a subsequent issue of *The New England Journal of Medicine*, there appeared this letter by Dr. Joan I. Venes and Dr. Peter R. Huttenlocher of the Yale University School of Medicine:

“As consultants to the newborn special-care unit, we wish to disassociate ourselves from the opinions expressed by the authors. The growing tendency to seek early death as a management option that the authors referred to has been repeatedly called to the attention of those involved and has caused us deep concern. It is troubling to us to hear young pediatric interns ask first ‘should we treat?’ rather than ‘how do we treat?’

“We are fearful that this feeling of nihilism may not remain restricted to the newborn special care unit. To suggest that the financial and psychological stresses imposed upon a family with the birth of a handicapped child constitutes sufficient justification for such a therapy of nihilism is untenable and allows us to escape what perhaps after all are the real issues—i.e., the obligation of an affluent society to provide financial support and the opportunity for a gainful life to its less fortunate citizens.” (emphasis added).

Has anyone else on the Yale faculty—in the humanities, in the law school—protested? Not to my knowledge.

Meanwhile, Dr. Duff has not changed his mind. And so far, he has had no legal difficulties as a result of withholding treatment from certain infants. At the end of the 1973 article, Duff and his colleague do ask: “What are the legal implications of actions like those described in this paper?”

Their answer: “Some persons may argue that the law has been broken, and others would contend otherwise. Perhaps more than anything else, the public and professional silence of a major social taboo and some common practices has been broken further. That seems appropriate, for out of the ensuing dialogue perhaps better choices for patients and families can be made. If working out these dilemmas in ways such as those we suggest is in violation of the law, we believe the law should be changed.”

If that last line did not chill you to the marrow, read it again.

The Duff-Campbell piece on death as a management option began to reach the lay world through a report in the November 12, 1983 issue of *Newsweek*. That story was read by Sondra Diamond with mounting rage. At, for instance, the prediction that these infant candidates for death had “little or no hope of achieving meaningful ‘humanhood.’” And that last line got her too: Change the law so that the killing can go with impunity.

Sondra Diamond also bridled, to say the least, at the use of the term, “vegetables,” in the *Newsweek* article to describe the newborns designated for death. Enough already. She wrote a letter, and it was published in the December 3, 1973, *Newsweek*:

“I’ll wager my entire root system and as much fertilizer as it would take to fill Yale University that you have never received a letter from a vegetable before this one; but, much as I resent the term, I must confess that I fit the description of a ‘vegetable’ as defined in this article . . .

“Due to severe brain damage incurred at birth, I am unable to dress myself, toilet myself, or write; my secretary is typing this letter. Many thousands of dollars had to be spent on my rehabilitation and education in order for me to reach my present professional status as Consulting Psychologist. My parents were also told 35 years ago that there was ‘little or no hope of achieving meaningful ‘humanhood’” for their daughter.

“Have I reached ‘humanhood’? Compared with Doctors Duff and Campbell, I believe I have surpassed it!

“Instead of changing the law to make it legal to weed out us ‘vegetables,’ let us change the laws so that we may receive quality in medical care, education and freedom to live as full and productive lives as our potentials allow.”

There is no telling, of course, how many of the infants who never checked out of Yale-New Haven Hospital’s special-care (*sic*) nursery might nowadays have been writing letters to the New York *Times* on behalf of Baby Jane Doe’s right to get spinal surgery. In any case, during the 1983 WNEV-TV (Boston) series, *Death in the Nursery*, there is an intriguing comment on Dr. Raymond Duff’s prophetic gifts in these matters.

The third part of that television report began with a look at Jimmy Arria and Kimberly Mekdeci. Jimmy, now eight, was born prematurely, weighing only four and a half pounds. By his second day of life, he had contracted pneumonia and suffered two seizures. Kimberly Mekdeci, one of his classmates, was born

with spina bifida (Baby Jane Doe's defect).

It was suggested to the parents of both Jimmy and Kimberly that they take death as the preferred management option so far as these babies were concerned. According to *Death in the Nursery*, this "unsolicited recommendation" came, in both cases, from none other than Dr. Raymond Duff.

On the television program, Kimberly's father, Ted, recalls that Dr. Duff "said that Kim would probably grow up to be a vegetable, her life would be meaningless."

Kim is no vegetable. Nor does she have any mental impairment. Jimmy, also recommended for extinction, is an A student in the public school system. Said Irene Arria, Jimmy's mother on *CBS Morning News* (May 18, 1982), "sometimes doctors can make mistakes, you know . . . this doctor . . . was willing to help us decide to let [Jimmy] die, when to me he was . . . worth saving in every way. And you can see that by the way he turned out."

And Kim's father, Ted, on *Death in the Nursery*: "Telling me I should kill my daughter! I would have killed him before I killed my daughter, if my friend wasn't there. 'Cause I had my hand half cocked and this is when my friend pulled me out of the room."

Dr. Duff refused to be interviewed for the program. No wonder.

A Case of Deformed Journalism at 60 Minutes

Children are not property whose disposition is left to parental discretion without hindrance.

—Cicero, New York State Supreme Court Bronx County, 1979

I will say it without qualification. I do not know of any long-running news story that has been as badly, misleadingly, and lazily covered as the case of Baby Jane Doe. (Her parents have named her Keri-Lynn, as revealed on March 14.) This story has been going on since October, and the news accounts and editorials contain the same bush league errors now that they did in the beginning. ("Spinal surgery may give her longer life, but cannot correct her severe retardation or ameliorate her pain": *New York Times* editorial, March 13.)

Three years ago, when journalists were squawking because the movie *Absence of Malice* had done a pretty good job of investigative reporting on reporters, the writer of the script, Karl Luedtke (part of a 1968 team at the *Detroit Free Press* that won a Pulitzer Prize) told me the journalistic key to the movie. Each of the stories the reporter in it wrote was accurate. But each one was not complete. Finally, therefore, each one was not true.

Except for some of *Newsday's* coverage at the beginning (not since) and that of Felicity Barringer at the *Washington Post*, the reporting on Keri-Lynn has been largely inaccurate as well as invariably incomplete, and therefore not at all true. Then, on March 11, CBS's *60 Minutes*, with the benefit of five months hindsight and its vaunted research staff, reached millions more with its story, "Baby Jane's Parents," than any news organization had before. And *60 Minutes* gave those millions of viewers the shoddiest report yet, a disgraceful contrast with the 1975 investigation that Mike Wallace and producer Joe Wershba did for *60 Minutes* in "To Live or Let Die," a piece on severely handicapped infants. Where the earlier program was as complex and sensitive as the subject, this year's "Baby Jane's Parents" was as flimsy and meretricious as if the show had been done for Channel 4's *Live at Five*.

Something Mario Cuomo said to me a few months ago bears on the herd journalism that has twisted this story from day one. "You know what happened?" the Governor said. "The reporters didn't analyze the case, and the editorial writers, also without doing any hard thinking, took the easy way out too. They took to criticizing 'the intruder,' the so-called Right-to-Life lawyer who kept bringing lawsuits on behalf of the infant. But they didn't think hard enough about whether the infant has rights of her own—rights that may be independent of what her parents decide for her." And hardly anybody in the press, including *60 Minutes*, found out much about the infant's handicap—spina bifida.

Now, let's take a look at "Baby Jane's Parents," reported by Ed Bradley and produced by Monika Jensen for *60 Minutes*.

On camera, Dan and Linda (no last names were given) were treated very, very gently. That figures. Very few reporters would want to cross-examine the parents of a handicapped baby in a way that might make them look as if they were insufficiently devoted to that baby. Or as if they had made a most unfortunate mistake about the baby's treatment. Not good for the journalist's image. But Ed Bradley might at least have probed and analyzed some of their assertions during other parts of the program. He preferred not to. It was as if he were in the presence of Mother Teresa.

Only A. Lawrence Washburn was given a hard time by Ed Bradley. But everybody gives Mr. Washburn a hard time, from editorial writers to this state's Court of Appeals to the Federal Judge in Albany who fined him \$500 for harassment because Washburn has brought so many court actions on behalf of this handicapped infant when he isn't even a member of the family, for God's sake. The nerve of this intruder—trying to preserve the infant's rights as a "person" under the Constitution by trying to get an independent advocate appointed for her so that she might have a chance to live longer and with a brighter mind than is likely under the "conservative treatment" chosen by her parents. A ter-

rible man, huh? Actually he's become one of my heroes.

Washburn was clearly the antiseptic villain of the *60 Minutes* show, the man who dared to question a mother's capacity to do the right thing for her baby. a zealot—foil for everybody else, very much including Ed Bradley. And so it was that Bradley let the parents' lawyers get away with saying that the record is free of any medical dispute concerning this case. And Bradley let the father get away with claiming that it is “total ignorance” to say, as Washburn had, that the infant, if operated on, would have had a reasonably good prognosis in terms of her mental development.

When *60 Minutes* was over, decent-minded folk throughout the land had been led to believe that these afflicted parents were being cruelly hounded by this nut, as well as by the Federal Government. And, they all probably said as they went to bed, what business does *anybody* have intruding on this sorrowing family? Unless the intruders are kind and understanding like Ed Bradley.

That's what *60 Minutes* is all about—fearlessly making complicated issues clear!

Here are a few facts, among many others, that somehow escaped Mr. Bradley and his producer, probably because, from the start, they were so sure how this story should be played that they shielded themselves from any facts that might inconveniently reveal their ignorance of what the story actually is.

Keri-Lynn is one of some 8000 babies born each year with spina bifida. As Dr. Anthony Gallo describes in the February, 1984, *Hastings Center Report*, spina bifida “results when the spinal column fails to fuse properly in fetal development. The meninges (membranes that cover the spinal cord) protrude in a sac through an open lesion.” This lesion can be repaired through surgery. The sooner the better. The Spina Bifida Association recommend that surgery take place within 24 hours of birth. Without surgery, there is a marked danger of infection that can lead to permanent brain damage.

This is the surgery that Keri-Lynn's parents have refused to allow. And there *has* been infection. Because the records are now open only to the parents, their doctor, and the hospital, no one else knows how long that infection lasted, how severe it was, and what effects it left, and whether there has been additional infection. There is evidence before infection set in—from the medical records of the first nine days, which *were* available—that the infant's prognosis was quite good. If surgery had taken place, it's possible there would have been little if any mental retardation. And there was a reasonable likelihood that she'd be able to walk with braces. Then the curtain came down, and Keri-Lynn was left in her privacy. Whether that is an awful privacy or not, we do not know.

None of this was on *60 Minutes*.

Practically all children with spina bifida also have hydrocephalus (“water on

the brain”). As Dr. Anthony Gallo notes: “. . . the normal cerebro-spinal fluid, a liquid that looks like water, accumulates within the brain and slowly squeezes the brain. The result is a markedly enlarged head, and, if not treated, usually significant degrees of mental retardation.” This can be treated “by inserting a shunt, a small device placed under the skin that drains the fluid from the brain into the abdominal cavity where it can be absorbed.”

If the shunt is not implanted, the head will get bigger and bigger, and the mental retardation worse and worse. The parents of Keri-Lynn refused to have a shunt implanted during the period of time when the records were open. My information is that the only shunting since then was temporary, and took place when antibiotics were given to the infant to treat her infection. A shunt was used to get the antibiotics directly into the fluid.

So far as is known, no shunt has yet been permanently implanted to reduce the pressure of the fluid on the brain. One expert in pediatric surgery to whom I’ve spoken says: “I know from the records of the first nine days that her head circumference, though called ‘abnormally small’ by your journalists, was compatible with normal intelligence. But by now, if there is no shunt, the circumference of her head could be as big as a football. If the parents had allowed the shunt to be implanted at the start, her prognosis is likely to have been much better.”

None of this was on *60 Minutes*.

Some of you may be wondering about the recent statements by Linda, the mother in the case, that insofar as the surgery to repair the lesion in the spinal column is concerned, there’s no longer any need for it—thereby confirming the wisdom of the parents’ original decision not to allow surgery. While revealing that she and her husband were now deciding whether to take five-month-old Keri-Lynn home or put her in “a permanent health care facility,” the mother told an unidentified New York *Post* reporter on March 15:

“Keri’s back has been sealed for months. It’s a joke that the government is still trying to force surgery on her . . . The baby’s back closed on its own. The skin grew over the opening naturally. If corrective surgery had been done, she would have been totally paralyzed. Now at least she has some feeling in her upper thighs.” The mother said much the same thing to Jerry Rosa in the March 16, 1984 *Daily News*.

The mother is misinformed, say a number of spina bifida experts who have seen medical testimony in the case. It is far from certain that Keri-Lynn would have been severely paralyzed if she had had the surgery, especially if the operation had taken place early on. No doctor I’ve interviewed believes she would have been totally paralyzed. And as for the back having sealed itself on its own, “It always happens if the child survives,” said Dr. Fred Epstein of New York University Medical School, a nationally respected pediatric surgeon. “The only purpose of

surgery is to make the back heal over sooner so there's no risk of infection."

The sooner the better. So it's hardly a "joke" that the Federal Government—which did not go into court to force surgery on the infant—*still* wants to look at the medical records to see what's been going on all along. Has this infant been discriminated against with regard to medical treatment because of her handicap? Also, remember if the surgery had been done at the beginning, the subsequent infection could have been prevented.

Furthermore, as a research associate of Dr. David McLone, Chief of Pediatric Neurosurgery at Children's Memorial Hospital, Chicago, and a specialist in spina bifida, told me: "Just because the skin grew back over does not necessarily mean there's any protection for the spinal cord under the skin, and it does not necessarily mean that the protective covering which is normally around the brain and spinal cord is there."

Getting back to the night *60 Minutes* turned to herd journalism, not a word was said on the program about the conflicting medical testimony in this case at an October 19 State Supreme Court hearing in Riverhead, Long Island. The parents' doctor, George Newman, a neurologist at Stony Brook Hospital, portrayed the infant's future as unrelieved misery and darkness of mind and soul. (What you've been reading in the New York *Times* boilerplate editorial and stories.) But also at the hearing was the chief of neurological surgery at the same hospital, Dr. Albert Butler, who has treated some 350 spina bifida children.

Dr. Butler testified that he would advise surgery; and when Dr. Newman assured one and all that it was unlikely the infant would ever develop any cognitive skills, the more experienced Butler disputed that judgment too. The parents' lawyer did get Butler to say that the parents' choice of treatment was medically appropriate, but most doctors do not like to go so far as to say publicly that a colleague, however misguided, has recommended the wrong course of treatment. And it was Butler, in an interview several weeks later in the November 9 *Newsday*, who said plainly that he favored "surgery in cases *medically identical* to those of Baby Jane because he believes such infants have far more potential than other Stony Brook physicians have predicted for the patient." (Emphasis added.) Butler had seen the baby and her records.

None of this was on *60 Minutes*, which allowed, indeed encouraged, millions of viewers to believe that the parents had done the very best they could do for their "deformed infant girl." (That sweetly non-judgmental phrase was in a CBS press release heralding the show. It's greatly inspirational for spina bifida kids in every state.)

Had the surgery and the shunting taken place, Kery-Lynn, in the years ahead, might have walked, with braces, and gone to school. At the least, she would have had a chance for more of a life. But what of the ceaseless pain that, accord-

ing to many sad-eyed editorial writers, would have been with her all the days of her life? (What a mercy, they imply, that now she won't have too many days.) Every pediatric surgeon I've interviewed, in this and other cities, has been appalled by the bruited about of such misinformation.

Says Dr. Fred Epstein of NYU Medical School: "Pain is absolutely not an integral part of the future of a spina bifida infant. Of course, she'll know pain, as we all do. More, because of multiple operations. But certainly not intrinsic, constant pain."

Journalists, print and broadcast, sure have brought a lot of honor to our profession in their reporting on Keri-Lynn.

Special Supplement:

Nat Hentoff on “life not worthy to be lived”

It is hardly news that, when the Supreme Court legalized abortion on demand in 1973, many predicted that infanticide, euthanasia, and other horrors would soon follow. The logic of the Court’s “quality of life ethic” clearly applies to human life at *any* stage. It only remains to legalize the “right to die” of “competent” persons and the “right” of parents to be rid of offspring that fail to meet their expectations, etc. It has long been obvious that there are plenty of doctors willing to collaborate (even instigate) the process of deliberately killing those whom German doctors—pioneers in the advocacy of such “treatment” even before Hitler came to power—once described as living lives “not worthy to be lived.”

Said legalization is not only well under way, but also gaining momentum. As with abortion, the courts are simply ignoring the *democratic* process: neither American citizens nor their elected representatives have been allowed to *vote* on the “new ethic,” which the news media generally favors *via* sensationalized reports lauding the “compassion” of the killers.

Not Mr. Nat Hentoff. In our Spring, 1984 issue, we reprinted his remarkable series of articles on the “Baby Doe” case in which courts were intervening to allow the killing of *born* citizens previously considered to enjoy full civil rights, including protection against infanticide on parental demand.

At that time we described Hentoff as “an unusual journalist by any standard. A prolific writer on a broad range of subjects, he considers himself what used to be called a Man of the Left, and, preeminently, a civil libertarian, allegiances which would seem to fit him comfortably for his journalistic base, *The Village Voice*, New York City’s ‘radical’ weekly.” All that remains accurate. We might have added that Hentoff is also an old-fashioned *reporter*, who digs deep into a story, and tells you a great deal that “modern” journalists either don’t find, or fail to report.

Last fall, Mr. Hentoff did another impressive *Village Voice* series on what used to be called “mercy killing,” but is now promoted as a generalized “right to die.” As before, we reprint the entire series here, for what we consider at least two good reasons: the *Voice* is probably not widely read outside Manhattan, while our journal is surely the “paper of record” of the defense-of-life movement—and the job Mr. Hentoff has done richly deserves to become a part of the permanent record we provide. Read on.

The Editors

The ‘Small Beginnings’ of Death

I. The American Death Squads

If the physician presumes to take into consideration in his work whether a life has value or not, the consequences are boundless and the physician becomes the most dangerous man in the state.

—Dr. Christoph Hufeland (1762-1836)

Leo Alexander, born in Austria, emigrated to the United States where he became a professor of psychiatric medicine in Boston. Surgeon General C. Everett Koop was a friend of Dr. Alexander and notes that Alexander “served as an expert at the Nuremberg trials of those physicians who had engineered the German euthanasia program and, eventually, the infamous medical experiments and genocide carried out by the Nazi regime.”

Since his first language had been German, Dr. Alexander gained the confidence of the physician-defendants and thereby uncovered a large amount of new information concerning the origins of the Holocaust in the German medical community and court system.

In the July 14, 1949 issue of the *New England Journal of Medicine*, Leo Alexander wrote an article, “Medical Science Under Dictatorship,” distilling his discoveries.

Alexander intended his essay as both an analysis of the beginnings of an unparalleled social malignancy and also as a warning to his adopted country. The killing of those who are no longer productive, no longer useful to their families or to the state, can happen here too, he said.

Dr. Alexander’s warning has been ignored.

Writing of the Third Reich, he emphasized that “whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings.”

“The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived.”

“This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanter [and] the racially unwanted. . . .”

“But it is important to realize that *the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitable sick.*” (Emphasis added.)

Not long before he died, Leo Alexander was greatly disturbed by an article he read in the April 12, 1984 *New England Journal of Medicine*, which had become the most influential medical publication in the country. Indeed, some of its pieces often break into the daily papers. This was one such article. When he'd finished the essay, Dr. Alexander shook his head, and said to a friend, “It is much like Germany in the ’20s and ’30s. The barriers against killing are coming down.”

The article was by 10 physicians from such prestigious institutions as Harvard Medical School, Johns Hopkins University School of Medicine, and the University of Virginia Medical Center. The title was: “The Physician’s Responsibility Toward Hopelessly Ill Patients.” With courtly expressions of great sympathy, these healers advocated the withdrawal of artificially administered nutritional support, including fluids, from various kinds of patients, such as those seriously and irreversibly demented. They were to be starved to death.

The 10 doctors, part of the growing “death with dignity” brigade, added that it is also “morally justifiable”—when a patient is in a “persistent vegetative state”—to withhold antibiotics and artificial nutrition (feeding tubes) and hydration, as well as other forms of life-sustaining treatment, allowing the patient to die.”

The last five words are, of course, classic newspeak. In situations like this—George Orwell could have told the 10 doctors—the patient is being killed. As University of Michigan law professor Yale Kamisar has been saying for nearly 30 years, the much revered “right to die”—whenever that decision is being made for, rather than by, a patient—is actually the right to kill.

The 10 doctors did go on to say that persistently vegetative patients ought not to be starved to death without first finding out “the patient’s prior wishes” and obtaining the agreement of the family. But a fundamental question, as we shall see, is whether in a civilized society, *any* human being, in *whatever* state, should be denied nutrition and fluids, no matter what *anybody* says. Second, what can really be determined from the patient’s prior wishes, even if the patient has made out a “living will”?

Sitting at home, watching Johnny Carson and sipping blackberry brandy, a healthy person making out a “living will” may not have the slightest idea what his or her wishes would actually be when death is no longer a word that applies only to everybody else. More of that as we go on.

What depressed Leo Alexander about that article, and about many other developments in American medicine and in the courts in the last 15 years, was

that the “small beginnings” of euthanasia in this country were now leading to more and more judicial killings.

A recent victim was Nancy Ellen Jobes in New Jersey. She died on August 7 after the Supreme Court of that state—which leads the nation’s courts in sanctifying the right-to-kill—ordered that her feeding tube be removed.

In this series, we shall see how we got to this point, as well as where we are going unless state legislatures wake up. (The courts, with few exceptions, are like Lewis Carroll’s Walrus, weeping over the fate of the oysters he is devouring on his walk along the beach.)

A preliminary view of what’s ahead can be found in “Against the Emerging Stream: Should Fluids and Nutritional Support be Discontinued?” in the January 1985 *Archives of Internal Medicine*. The authors are Alan J. Weisbard, now the director of the New Jersey Bioethics Commission, and Dr. Mark Siegler, Professor of Medicine at the University of Chicago. They say something you will not see in a New York *Times* editorial. For that matter, the *Times* in its news pages as well, practices advocacy journalism when it comes to euthanasia. The paper’s theme song is Bach’s “Come, Sweet Death.”

“We have deep concerns,” say Siegler and Weisbard, “about accepting the practice of withholding fluids from patients because it may bear the seeds of unacceptable social consequences. We have witnessed too much history to disregard how easily a society may devalue the lives of the ‘unproductive.’ The ‘angel of mercy’ can become the fanatic, bringing the ‘comfort’ of death to some who do not clearly want it, then to others who ‘would really be better off dead,’ and finally, to classes of ‘undesirable persons,’ which might include the terminally ill, the permanently unconscious, the severely senile, the pleasantly senile, the retarded, the incurably or chronically ill, and perhaps the aged.”

And remember, most of these folks cost a lot to keep alive. Aren’t there better ways to spend the money? Like on education, more middle-income housing, cleaner air? Put the choice to a vote, anywhere in the United States: money for good things for the majority of society as against money for those who would be “better off dead.” Which side would win?

But we’re not quite ready to put that sort of stuff on the ballot—yet.

Apart from how such a plebiscite would come out, the herd journalism of the press in covering the national slide toward euthanasia results in a general sigh of sympathetic relief among the citizenry when any of these “vegetables” dies.

I’ll be going into some detail on the case of Nancy Ellen Jobes as this series goes on, but preliminarily, the brief news accounts of her forced departure from among us noted that she had been in a vegetative state since 1980. Pregnant, she had been involved in a car accident and during surgery to remove the dead fetus, a loss of oxygen and blood flow to the brain caused her to fall into a

coma-like condition. Her family had been trying to get her feeding tube removed against the wishes—on ethical grounds—of the Lincoln Park Nursing Home, where Nancy Ellen Jobes had lived for nearly all the past seven years. At last, the New Jersey Supreme Court had approved the removal of the tube, and the United States Supreme Court refused to intervene.

Editorially, the New York *Times* hailed the decision of the New Jersey Supreme Court to let Nancy Ellen Jobes be killed. The Court, said the *Times*, had released “Mrs. Jobes from tragic burdens of life on the threshold of death.”

Well, now, *was* Nancy Ellen Jobes in a persistent vegetative state? Was she “on the threshold of death?” During attempts by the Lincoln Park Nursing Home and others to prevent the state from killing her, two nationally renowned neurologists testified. One, Dr. Albert E. Ropper, professor of medicine at Harvard Medical School and director of the Neurosurgery-Neurology Intensive Care Unit at Massachusetts General Hospital, said he had examined Mrs. Jobes and that she had followed a number of his commands (like, on request, moving her foot and toes, her legs, and sticking out her tongue). She followed his fingers, and from other indices, he concluded that while she was severely brain-damaged, she was *not* in a persistent vegetative state.

A similar conclusion was made by Dr. Maurice Victor, professor of neurosurgery at Case Western Reserve University School of Medicine. He too had examined Nancy Ellen Jobes, and he too had concluded that while seriously brain-damaged, she fell outside the category of a persistent vegetative state.

“I gave her a number of verbal requests,” Dr. Victor testified last year, “and it became apparent the patient could hear and understand what I was saying. . . . As I asked her to perform the tasks, I saw a look of intentness. She looked attentive . . . [to] what she was doing. I am convinced this patient has a repertory of emotional expressions.”

There was contrary testimony by such opposing experts as Dr. Fred Plum, professor and chairman of the Department of Neurology of New York Hospital-Cornell Medical Center. And another neurologist said: “She died a long time ago. . . . She should have a funeral.”

While this was going on, I received a letter from a friend of mine who visited Nancy Ellen Jobes last year. This observer, a researcher, is uncommonly precise, as I’ve had reason to learn in my work through the years. This is what my friend wrote:

“I am more appalled than ever that anyone would consider starving Mary Ellen Jobes to death. She is not comatose. She is severely disabled and very vulnerable.

Nancy appeared alert and aware of people entering her room and showing things to her. She looked directly at me and then at others

and then back to me as I spoke to her. She has a lovely smile. When I told her so and that it would be nice to see that smile again, she smiled more broadly.

Yes, there was conflicting testimony. Yet, as Dr. Norman G. Levinsky, Chairman of the Department of Medicine at Boston University's School of Medicine says, "given any reasonable doubt about the choice between life and death [with regard to] a specific patient, doctors should choose to fight for life." And Nancy Ellen Jobses could have lived for many years.

As we shall see, fewer doctors each year are fighting for certain patients' lives. Instead, they are helping the courts ease the removal of more barriers to killing. When Nancy Ellen Jobses died, the United Handicapped Federation—but not any medical association—protested her having been starved to death. "She was welcome in the disability rights community," these mourners said.

"It is now a capital offense," said an anti-euthanasia group, "to be young, brain-damaged"—and too tenacious to die.

II. The Deadly Slippery Slope

In five or ten years, maybe sooner, one or more states will have made active euthanasia legal. That is, a physician will have the authority—on request of an "irreversibly ill" patient—to kill him or her. Not just, as is increasingly legal now, "letting the patient die" by starvation or by removing a respirator. What is coming here, as is already in place in Holland, is the power to actively remove the patient by an injection of barbiturates along with curare. Swiftly and painlessly.

The Hemlock Society has already planned three "Physician Aid in Dying Bills" for California, Arizona, and Florida. Lots of old folks there. And there has been considerable admiring press coverage throughout America at how advanced the Dutch have become in welcoming death.

A *60 Minutes* segment last year estimated that a sixth of those who die every year in Holland—some 20,000—are dispatched by doctors. Oh, there are safeguards against abuses of that final injection. The instruction to end it all must come from a fully conscious patient. A second physician must agree. There must clearly be no hope of the patient's recovery, and the patient's physical or mental suffering must be unbearable. All pain-killing remedies must have failed.

Moreover, relatives do not have the power to make this final decision on behalf of patients who are no longer competent. The last word can come only from the patient.

Some physicians in the Netherlands are rather uncomfortable at assisting suicides. "It goes against the grain," one of them says. Physicians, after all, are trained to heal, not to kill. Still, physicians, like the rest of us, can find noble reasons for going against the grain. Here, it is the ending of human misery. Surely, that's a form of healing.

Other Dutch physicians have darker fears. Cardiologist Dr. Van der Does told Ed Bradley of *60 Minutes* that he believes this opening to lawful killing by doctors could lead to active euthanasia in such other cases as handicapped newborns or patients in comas.

"I think it is a point of no return," says the cardiologist. "Once you say euthanasia is permitted in certain cases, I don't think it will be possible to stop somewhere along that track."

The Netherlands, however, is a very civilized country. Surely the medical establishment and the courts will be able to keep euthanasia in its place.

Well, let's look at the American experience. By some reports, this is a civilized country. How successful have we been in keeping euthanasia contained? People who thought about these things in 1976 could never have imagined how far down the deadly slippery slope we would slide in just 11 years. In 1976, the New Jersey Supreme Court agreed to the request of Karen Ann Quinlan's parents that her respirator be disconnected. She was 21, and the year before she had fallen into a coma after consuming a combination of alcohol and tranquilizers.

A lower court had refused to disconnect the respirator even though doctors has testified that she was brain dead and was "dying." Actually, Quinlan was not dying and she was not "brain dead." Psychology professor Daniel Robinson of Georgetown University, an expert in these matters, noted at the time that the clinical picture "will not and cannot support a claim of 'brain death,' even on the loosest acceptance of the term."

But New Jersey's highest court, as a first step toward leading the nation's courts into the fathomless depths of euthanasia, ordered the respirator turned off because of Karen Ann Quinlan's "right to privacy." That is, if she were conscious, the court said, she would have the privacy right to hasten her own death. But since she was not competent, her family had the right to exercise their "substitute" judgment as to what she would have decided under those circumstances. As it happened, she lived—without the respirator—until June 1985.

It is important to note that in 1976, while turning off a respirator was not entirely shocking to some Americans, the prospect of ever depriving Karen Ann Quinlan of artificially administered nutrition and fluids repelled a lot of people. Including Karen Ann Quinlan's family. When asked if he also wanted her intravenous feeding ended, her father said, "Oh no, this is her nourishment!" The court agreed.

But that was when Americans were still quite unsophisticated in dealing with the soft killing fields of euthanasia.

Yale Kamisar, more usefully than anyone else, has illuminated the historic significance of the Quinlan case. He is the country's leading expert on the Fourth and Fifth Amendments, among other areas of Constitutional law. And when a search and seizure of *Miranda* decision comes down from the Supreme Court, Kamisar is usually the first name on the list for Supreme Court reporters to call for comment. But he is seldom called by the press when there are new legal developments in euthanasia.

Kamisar's views on this kind of killing are against the grain these days. He is, to begin with, an unrelenting enemy of newspeak; and like the cardiologist in Holland, Kamisar is not at all sure that it is possible to stop euthanasia "somewhere along" the slippery slope once the momentum is really rolling. And it sure is rolling in the United States. So Kamisar, in his analytical way, keeps sounding warnings.

With regard to Karen Ann Quinlan, Kamisar has pointed out that until the 1976 Quinlan case, proponents of euthanasia—to show how cautious and responsible they were—used to emphasize that they wanted to quicken death only for patients: (1) who themselves asked for death; (2) who were suffering unbearable pain; and (3) who were already close to death.

Karen Ann Quinlan, however, was not capable of speaking on the question, so the request to remove her respirator was not made by her. Also, she was not in pain, and she was not near death. Yet the respirator was removed.

Kamisar makes another point that underscores the remarkable resiliency of some of the advocates of euthanasia. Norman Cantor, a professor at Rutgers Law School, was much pleased by the *Quinlan* decision. Yet two years before the same Professor Cantor had written:

The most serious argument against voluntary euthanasia—that it would eventually lead to involuntary euthanasia—is not convincing because so long as careful attention is paid to the capacity of a person to request euthanasia, there is a large gap between voluntary euthanasia and involuntary elimination of societal misfits.

So what happened to that "large gap" in 1976, when the court ruled that Karen Ann Quinlan's parents could decide for her when she would die? It has greatly narrowed, Yale Kamisar points out.

Professor Cantor continues to speed down the slope. In a recent *New Jersey Law Journal* article, Cantor mightily approved of this year's New Jersey Su-

preme Court decision which allowed a feeding tube to be removed from Nancy Ellen Jobes. The decision also said that the nursing home where she lived could be forced to kill her by removing the tube. The Lincoln Park Nursing Home has a strange ethical reluctance to kill its patients, and refused to take away the tube. (The issue became moot when Nancy Ellen Jobes was transferred to Morristown Memorial Hospital, where she died.)

Well, Professor Cantor notes, “It has often been held that even individual conscience must yield to important public policies.”

The state orders a killing, and everyone must obey. Sound familiar?

Then there was another landmark case, that of Claire Conroy. She was 84, lived in a nursing home, had a number of ailments, was senile, experienced pleasure when receiving care, smiling during a back rub, for instance. She was fed through a nasogastric tube that went through her nose and down into her stomach.

Claire Conroy’s nephew (her guardian) went to court to have the tube removed. Her second, court-appointed guardian and her physician disagreed, the latter because he did not believe that it would be acceptable medical practice to starve the old woman to death. A Catholic priest—Claire Conroy was Catholic—supported the nephew. Oh, it would be a painful experience for Ms. Conroy but, in the end, all to the good. (There are deep divisions among Catholic bioethicists and theologians concerning euthanasia, as we shall see, with one, Father John J. Paris of Holy Cross College, a familiar witness for death.)

Claire Conroy died while all the learned souls argued her fate, but the New Jersey Supreme Court kept the case alive because the judges figured it was more important than Claire herself. At the time, various authorities praised the Court’s eventual ruling for the strictures it imposed on too sweeping a use of euthanasia. But these limitations have largely proved porous.

Legally, the most significant element of the Conroy decision was the declaration—for the first time by any state Supreme Court—that feeding tubes can be considered optional treatment, just as optional as respirators. Until then, nutrition had been considered basic—not optional—to care.

No longer was nutrition to be continued, no matter what else was decided. Starving certain kinds of people to death had become legal! So much for what Daniel Callahan, director of the Hastings Center (of bioethics) has called “the most fundamental of human relationships”—feeding the hungry. “It is the perfect symbol of the fact that human life is inescapably social and communal. We cannot live at all unless others are prepared to give us food and water when we need them.”

The New Jersey Supreme Court had used the Conroy case to smash that “perfect symbol.” Before it rested that day, however, the Court tried to narrow

the application of its ruling. Feeding tubes could be removed only from nursing home patients expected to die within a year, and only if those patients clearly wanted the tubes removed. And if the benefits of continued life were outweighed by the burdens of treatment. The burden of intractable pain, for instance.

Claire Conroy hadn't given permission to remove the tube; and was not in unbearable pain. Whether her death within a year could have been predicted when the case started is not clear. But she did die before the court could weigh her own life, though it used her case to set regulations for our lives.

In fairness, it has to be said that the *Conroy* court made an important promise about future cases in which families or guardians of incompetent patients want the legal authority to kill them:

We expressly decline to authorize decision-making based on assessments of the personal worth or social utility of another's life, or the value of that life to others.

We do not believe that it would be appropriate for a court to designate a person with the authority to determine that someone else's life is not worth living simply because, to that person, the patient's "quality of life" or value to society seems negligible.

The mere fact that a patient's functioning is limited or his prognosis dim does not mean that he is not enjoying what remains of his life or that it is in his best interests to die. . . .

More wide-ranging powers to make decisions about other people's lives, in our view, would create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps.

The Conroy case, therefore, resulted in a bizarre split decision by the New Jersey Supreme Court. On the one hand, it overturned many thousands of years of human values by legalizing starvation. On the other hand, the court showed a rare sensitivity to the flood-like dangers of legally killing people on the basis of their "quality of life"—like those suffering physical and mental handicaps.

This year, the New Jersey Supreme Court broke its promise not to authorize life-and-death decisions on the basis of an individual's "quality of life." It authorized the killing of Nancy Ellen Jobes because her "quality of life" wasn't good enough.

See how far we have come in only 11 years. And consider how many more people are not, some say, worth keeping alive.

III. The Death Doctors

Margaret Mead used to point out that before the fifth century B.C., when the doctor came calling, the patient could not be sure whether he was going to be cared for or killed.

“Throughout the primitive world,” she noted, “the doctor and the sorcerer tended to be the same person. . . . He who had the power to cure would necessarily be able to kill.” Depending on who was paying the bill, the doctor-witch doctor could try to relieve the pain or send the patient to another world.

Then came a profound change in the consciousness of the medical profession—made both literal and symbolic in the Hippocratic Oath: “. . . I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give a woman a pessary to cause abortion. . . .”

It was an extraordinary moment in the history of civilization. As Margaret Mead said, “For the first time in our tradition there was a complete separation between killing and curing. . . . With the Greeks, the distinction was made clear. One profession . . . was to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect—the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child.

“This is a priceless possession which we cannot afford to tarnish,” Mead emphasized, “but society always is attempting to make the physician into a killer—to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. . . . It is the duty of society to protect the physician from such requests.”

During 25 centuries, there have been backslidings—as in times of war and conquest—but by and large, the Hippocratic ideal, however dented from time to time, prevailed. The job of the physician was to heal, not to kill.

In 1920, however, a small book, *Consent to the Extermination of Life Unworthy To Be Lived*, was published in Germany. The authors were a distinguished psychiatrist (Alfred Hoche) and a prominent jurist (Karl Binding). The book was enormously influential. It smashed the Hippocratic Oath, once again giving doctors permission to kill. To kill those whose lives were not worth living.

Dr. Leo Alexander, who served with the Office of the Chief of Counsel for War Crimes in Nuremberg, described in a 1949 *New England Journal of Medicine* article how far down the killing slope the German medical profession had gone by September 1, 1939, when Hitler gave his first direct order for euthana-

sia. Wrote Dr. Alexander:

All state institutions were required to report on patients who had been ill five years or more and who were unable to work, by filling out questionnaires giving name, race, marital status, nationality, next of kin, whether regularly visited and by whom, who bore financial responsibility, and so forth.

The decision regarding which patients should be killed was made entirely on the basis of this brief information by expert consultants, most of whom were professors of psychiatry in the key universities. These consultants never saw the patients themselves. . . .

There was a parallel organization “devoted exclusively to the killing of children.”

In Germany, as everywhere euthanasia has been practiced, the authorities were skilled at euphemism. Patients were transported to the killing centers by “The Charitable Transport Company for the Sick.”

Dr. Alexander had access to many records of the Nazi regime, and one of the most illuminating documents is a report by a member of the court of appeals at Frankfurt-am-Main in December 1939. It adds proof that the Holocaust began with the mass killing of the old, the “feeble-minded,” the chronically ill, and those with multiple sclerosis, Parkinsonism, and brain tumors. Also severely handicapped children. Unwanted, 275,000 of them were exterminated. This was a dress rehearsal for the annihilation of six million Jews and millions of others.

Carrying out this genocide were the death doctors, the finely trained ornaments of German medicine. They truly believed, as many American doctors do now, that certain lives are not worth living—and besides, are too costly to sustain.

The German court of appeals judge wrote in 1939:

There is constant discussion of the question of socially unfit life—in the places where there are mental institutions, in neighboring towns, sometimes over a large area, throughout the Rhineland, for example. The people have come to recognize the vehicles in which the patients are taken from their original institution and from there to the liquidation institution. I am told that when they see these buses, even the children call out: “They’re taking some more people to be gassed.”

In 1987, we, of course, have no such vehicles in the streets. Nancy Ellen Jobs and others who have been starved to death die far from the crowd. The children are spared from seeing the tumbrils. And patients are not gassed in this country. What an uproar there would be if that were so! But we are eminently

civilized. We kill one at a time.

When the buses, with the shades drawn, pulled up to the liquidation institutions in Germany, arrivals were “immediately stripped to the skin, dressed in paper shirts, and forthwith taken to a gas chamber, where they were liquidated with hydrocyanic acid gas and an added anesthetic. The bodies are reported to be moved to a combustion chamber by means of a conveyor belt, six bodies to a furnace. The resulting ashes are then distributed into six urns which are shipped to the families. . . .

“There is talk, furthermore, that in some cases heads and other portions of the body are removed for anatomical examinations. The people working at this liquidation job in the institutions are said to be assigned from other areas and are shunned completely by the populace. This personnel is described as frequenting the bars at night and drinking heavily.”

There is certainly no parallel between what has just been described and the practitioners of euthanasia in America, 1987. Our retail killers are among the most honored physicians in the land and they are supported in their work of compassion by bioethicists, some of them priests, who are also festooned with advanced degrees. And instead of being pariahs at run-down bars, these physicians and bioethicists testify before legislative committees and are deferred to on television and in the print press.

The Germans at least had the good grace to feel queasy—at this early stage—in the presence of the killers of the old, the unfit, the schizophrenic, the too expensive to keep alive. And people in the towns, said the appellate judge in Frankfurt-am-Main in 1939, were “disquieted by the question of whether old folk who have worked hard all their lives and maybe have come into their dotage are also being liquidated. There is talk that the homes for the aged are to be cleaned out too.”

New York’s Society for the Right to Die, as its name makes clear, believes in “death with dignity”—a common way these days of advocating euthanasia. In its summer 1987 newsletter, there is this note:

There are about 3 million Americans over 85 and the number is rapidly growing. Of those institutionalized, the American Health Care Association represents some 8,000 facilities, which now shelter 800,000 people, with an average age of 84. Most suffer from more than one ailment and require help in several activities of daily living. Some 50% are mentally or decisionally impaired to some degree.

Now why do you suppose the Society for the Right to Die felt it useful to give its members this information? Is it to show how much merciful work has yet to be done? I got a chill seeing this data in that place. I think that Dr. Leo Alexander would have felt a chill too. As he said not long before he died in 1984, “It is much like Germany in the ‘20s and ‘30s, The barriers against killing are coming down.”

As the barriers fall in America, there is no particular drama. No buses, with shades drawn, go through your neighborhoods to the killing centers. The American way of putting Hippocrates into a broom closet was best described in an April 1986 article in *Commentary*, “Therefore Choose Death?” One author is Paul Appelbaum, professor of psychiatry and director of the Law and Psychiatry Program at the University of Massachusetts School of Medicine. The co-author is Joel Klein, a lawyer.

They claim, with illustrative accounts, that there has taken place in America, “the abandonment by the medical profession of an unambivalent commitment to the treatment of the ill.”

And they quote a physician disinclined to use his name: “The old, chronically ill, debilitated, or mentally impaired do not receive the same level of medical evaluation and treatment as do the young, acutely ill, and mentally normal. We do not discuss this reality or debate its ethics, *but the fact remains that many patients are allowed to die by the withholding of ‘all available care.’* There seems to be, however, a general denial of this reality.” (Emphasis added.)

Recently, the medical director of the Long Term Care Division of Pima County’s Department of Aging and Medical Services in Arizona testified that “the vast majority” of nursing home deaths in Pima County were caused by dehydration. The patients’ physicians had decided to care for them by cutting off all fluids. There are no gas chambers in Arizona. But it could be said that there, and everywhere else in the United States, there are liquidation institutions for certain old folks.

Another index of the state of the Hippocratic Oath in America—doctor or witch doctor?—was a startling decision last year by the seven-member council on ethical and judicial affairs of the American Medical Association. The ruling, which is supported by the AMA itself, says that it is ethical for doctors to withhold “all means of life-prolonging medical treatment,” *including food and water*, if a patient is in a coma that “is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis.” This holds “even if death is not imminent.”

This ruling—described as “welcome” in a New York *Times* editorial—is full of lethal holes. To begin with, Dr. Nancy Dickery, chairman of this AMA council that says starving a patient to death is ethical, admits that “there is no

definition of adequate safeguards . . . no checklist” that doctors would have to fill out in each case. As University of Michigan law professor Yale Kamisar notes, it’s hardly unknown for doctors to make “all kinds of mistakes in their diagnosis.” As has been abundantly evident in malpractice cases.

But some mistakes can’t be taken back.

I was particularly intrigued by the statement of Dr. Dickey’s council that on the one hand it’s okay for doctors to starve a patient to death, but a doctor “should not intentionally cause death.”

Come again?

Why are Dr. Dickey and the AMA afraid of honest language? Why not say, “We have decided that doctors have permission to kill?”

When the AMA license to starve patients was announced, I talked to Dr. Norman Levinsky, chief of medicine at Boston University Medical Center, and one of the relatively few bioethicists with a presumption for life.

The AMA ruling, Dr. Levinsky said, “gives doctors and other care-givers a message that it’s okay to kill the dying and get it over with. It ought to be difficult for doctors to stop doing things for their patients, but this makes it a little easier. Also, it is not a huge step from stopping the feeding to giving the patient a little more morphine to speed his end. I mean, it is not a big step from passive to active euthanasia.

“Also,” Dr. Levinsky added, “I have no question that some physicians and other care-givers consider the life of someone over 80 to be less worthy than that of someone who is 28. This approval by the AMA of withholding food and water could accelerate that kind of medical care.”

In the Germany of 1939, the staff of the euthanasia centers would drink too much in the bars at night because they were ashamed of their work. Is anybody ashamed here? Now?

IV. The Useless Eaters

One thing we haven’t mentioned here, and it’s almost a dirty thought. Doesn’t society have the right to question spending all those vast resources for old people—some of whom may be in a chronic vegetative state—when the money might be spent to educate the young and in other ways?

Fred Graham, moderator, *Face the Nation*, CBS-TV, September 1, 1985

After the first column in this series, I received a note from Doc Pomus, an evocative and long-playing songwriter (“Save The Last Dance for Me,” “Little Sister,” “Young Blood”). He’s also an astute judge of emerging talent—including, as I’ve had reason to discover—in the country music field.

Doc wrote:

“You verbalized everything on the subject of ‘euthanasia’ that has frightened me for years. Where or when does the cessation of life begin or end when it’s put into the hands of another person? Next, it’s the death of old people because they’re aging, and that’s followed soon afterwards by killing off the physically handicapped.

“As you know, I’m in a wheelchair and I can feel those bastards breathing down my neck.”

Doc has been in a wheelchair since a bad fall in 1965. He’s still very much a part of the scene. Practically every time I’m in the Lone Star, Doc’s there, grooving.

His note reminded me of a close friend, Charles Mingus. He had amyotrophic lateral sclerosis (“Lou Gehrig’s disease”) and, in time, Mingus, in a wheel chair, could no longer speak. But his eyes were saying a lot. He wanted to live. He and his wife, Susan, traveled wherever there might be hope, and he died in Mexico where he had gone on another chance.

There are people, though, with a clear mind locked in a frozen body, who want to die. Murray Pitzer, for instance, in New Jersey. After a stroke three-and-a-half years ago, the only physical functions he could perform were nodding his head and blinking his eyes. By nodding, he spelled out “euthanasia” to his wife, and in July, an Essex County judge gave his wife permission to remove the feeding tube from her husband’s stomach.

According to a previous ruling by the New Jersey Supreme Court, in June, a family member who, in “good faith,” implements such a decision by a competent patient is not criminally liable for his death.

If you’re against euthanasia, how do you deal with patients with clear minds who want to die?

To begin with, according to common law, a conscious, competent patient can refuse treatment, including surgery, no matter what his doctor advises and even if that refusal will result in his death. But there are qualifications. The adult—and we’re talking about adults—has to have the ability to understand the consequences of his decision. If, let’s say, the patient is clinically depressed (not just in low spirits), his ability to decide anything is badly clouded.

For example, in 1984, Andrew Malcolm, the New York *Times* specialist in euthanasia, wrote a piece about suicide among the ailing elderly. It was one of Malcolm’s characteristically lyrical prose poems welcoming death. You could almost hear the musical background—Brahms, with a touch of Paul McCartney.

What a lovely way to go gentle into that good night.

The *Times* printed a letter commenting on the piece by Dr. George L. Ponomareff of Hayward, California:

A September 24 news article described the tragic circumstances of several elderly people who committed suicide, but it failed to note that most suicides by the elderly are not a reasoned response to unremitting pain or the prospects of total physical dependency. In fact, *suicide in the elderly, as in any other age group, is most often related to depressive illnesses.*

Substantial advances in both the pharmacologic and psychotherapeutic treatments of depression have resulted in a situation in which the majority of patients suffering from depression can be relieved of their symptoms. Unfortunately, in too many cases, both families and treating physicians fail to recognize that clinical depression—and not “old age”—is at the root of the patient’s despair. (Emphasis added.)

So, being conscious does not necessarily mean being competent to decide to die.

Another caveat. While a truly competent patient does have the right to refuse treatment, suicide is something else. That is, if the patient asks for enough barbiturates or morphine so that he can commit suicide, a physician who goes along with the request may be liable to civil and criminal penalties.

But if some of the right-to-die societies, now on a roll in the courts, have their way, physicians will be legally permitted by state legislatures to practice active as well as passive euthanasia. Sooner rather than later.

But what about a non-depressed competent patient like Murray Pitzer, who wants a form of treatment, his feeding tube, removed, entirely aware that it will result in his death? He’s not asking for morphine. He’s pressing for his common law right to refuse treatment.

One very active opponent of euthanasia, Jane Hoyt, chairperson of the Nursing Home Action Group in St. Paul, Minnesota, tells me:

For informed, competent persons who do demand death, the issue is complex. While respecting the autonomy of the person, we have an affirmative duty to inquire *why* a person would view dying as being preferable to living. If there is some reason which society can ameliorate, we should of course provide help so the person continues living with us in our community. Failure to question a desire for an expeditious death constitutes neglect.

I agree that patient decisions to stop treatment ought not to be instantly granted. Not only should it first be determined whether clinical depression has shaped the decision but also, as Jane Hoyt says, other questions ought to be asked. For instance, especially among the elderly, does the patient feel a “duty” to die? It’s costing his family so much money to keep him in that bed. And it looks as if he’ll never be able to work, to be productive, again. He has become, as officials of the Third Reich used to say, a “useless eater.”

In a phone conversation, University of Michigan law professor Yale Kamisar adopts for me the tone of a financially burdened son visiting his 80-year-old, institutionalized father: “I see Mr. Smith in the next room stopped his treatment last week. Too bad, but it’s a brave way to go, dad.”

When the son leaves, Kamisar adds, his dad wonders, with renewed guilt, “Am I being a coward? Am I being selfish?”

This kind of death wish is suspect. The guilt could lift. Indeed, there are care givers—not just psychiatrists—who might be able to get the life forces flowing again, despite the children.

In any case, the pressures on the old in America are there, and they’re rising all the time. (An impatient child of a parent over 80 might well be able to speed his parent’s departure by leaving in his hospital room a copy of Daniel Callahan’s “Limiting Health Care for the Old” in the August 15-22 *Nation*. Callahan is the director of the Hastings Center, and his piece—in the wintry spirit of former Governor Richard Lamm of Colorado—shows what can happen to you if you hang out with bioethicists too long.)

But what about a fully conscious patient like Murray Pitzer—who is not clinically depressed and is not being pressured to die? Nevertheless, he or she wants it over with. Period. Under those circumstances, it seems to me, the fundamental right to self-determination includes the right to end the self.

The great majority of euthanasia cases, however, do not involve a truly conscious and competent patient. At risk of being killed are people in the kinds of conditions described in previous columns in this series. They are in a “persistent vegetative state” or senile or otherwise incompetent.

Yet, because of relatively recent court decisions, the incompetent now also have the right to refuse treatment. How? Through the “substituted judgment” of family members or others whom the patient, when competent, has designated. This—as we have seen and will see again—leads to many problems. And deaths.

Many of those marked for euthanasia by the “substituted judgment” of others are elderly. The Surgeon General, C. Everett Koop, has been warning for years about the rapid rise in the killing of those “who do not die within an acceptable time frame as determined by their families or society.” (According to polls, American society is overwhelmingly in favor of euthanasia.)

In a talk last year at Notre Dame University Law School, Dr. Koop focused on the dangers to the elderly from this national impatience with their “biological tenaciousness.” Looking ahead, Koop noted:

During the next 45 years, the number of persons above the age of 65 will increase 100 per cent, from 29 million to at least 64 million. During the same time, the number of persons in the range of ages 20 to 64—the likely wage earners—will increase only 30 per cent, from 145 million to 185 million.

Thus, where there are now five young and middle-aged adults to care for every elderly person, there will only be three by the time the students among you reach your retirement.

And by 2040, 45 per cent of all health expenditures will be spent on the elderly.

Koop also mentioned—and any doctor will confirm this—the increasingly intense focus on the costs of medical care. The Federal government is keeping a cold eye on those costs, as are the hospitals and the third-party payers of those costs and fees.

In “Life, Death and the Dollar Sign,” an article in the July 13, 1984, *Journal of the American Medical Association*, Dr. Dana Johnson of the University of Minnesota Medical School wrote with apprehension of how financial considerations have entered into “life-and-death decisions.”

For instance, until fairly recently, the “astronomical costs of long-term life support made most families liable for some costs and frequently resulted in extremely burdensome debts, despite third-party reimbursement. Nevertheless, in situations wherein the prognosis was truly gray, a decision in favor of supporting life despite the cost usually could be ensured through the strong emotional bond of the family and the advocacy of the patient’s physician.”

But now, with doctors, hospitals and families increasingly squeezed by cost controls—as third-party reimbursers have come to frown on the biologically tenacious—the climate has markedly changed. As Dr. Johnson points out, “In cases wherein the patient’s best interests are unclear and the prognosis is truly gray, decisions may be ... subtly tipped in favor of discontinuing life support on the basis of financial considerations.”

And as time goes on the tipping toward death will become a lot less subtle, what with the respectability of euthanasia having come along at just the right time to “solve” the costs of long-term care.

Dr. Dana Johnson asks: “What patient groups will be the first victims of this burden of cost containment? The same groups that are now most vulnerable—

the handicapped, the retarded, the chronically ill, and the poor.”

And the elderly.

Albert Camus’s *Neither Victims Nor Executioners* begins: “The 17th century was the century of mathematics, the 18th that of the physical sciences, and the 19th that of biology. Our 20th century is the century of fear.”

To which Dr. Koop adds that, as the Third Reich should have taught us, “no society can risk the profound evil of devaluating the life of any human being, no matter how profoundly that life may be impaired.”

V. Should Paul Brophy Have Been Put to Death?

There is always hope for a tree: when felled, it can start its life again; its shoots continue to sprout. Its roots may be decayed in the earth, its stump withering in the soil, but let it scent the water, and it buds, and puts out branches like a new plant. . . .

But man Once in his resting place, [he] will never rise again.

—BOOK OF JOB, Chapter 14, verses 7-11

If I were teaching a course on the moral, legal and medical thickets of euthanasia, the case I would begin with—and end with—is *Brophy v. New England Sinai Hospital*. It includes particularly compelling arguments for no longer providing food and water to a patient. The same case provides particularly compelling arguments for not denying a patient food and water.

How is this possible in the same case? That’s why it is such a landmark case. As Father John Paris, a Jesuit and professor of ethics at Holy Cross College, said outside the courtroom during one of the hearings, the decision would affect thousands of other patients across the country.

The Brophy case has also been the most widely reported euthanasia litigation so far. In addition to intensive coverage in the *Boston Globe*, it was reported on in detail in the *New York Times* and other papers across the country, and segments of the *Today* show and *20/20* were devoted to it.

This press coverage will also affect thousands of other patients around the country for, with few exceptions, the stories—especially on the national television programs—were heavily weighted against Paul Brophy’s right to live. The focus instead was on his wife who, after much agony and prayer, had asked that he no longer receive food and water. The rest of Paul Brophy’s family agreed with her.

Another dimension of this case—only cursorily covered in the press—was the refusal of the Physician-in-Chief at New England Sinai Hospital—and the

refusal as well of Brophy's attending physician—to participate in the removal of food and water from this or any other patient. In the background of one of those physicians was a reason for this unalterable stand, which, I expect, will startle you when we get to it.

I intend to present the medical facts, followed by the strongest arguments on both sides. And I welcome responses from you. After hearing it all, I want to know: do you think Paul Brophy should have been put to death?

Paul Brophy lived in Easton, Massachusetts, with his wife, Patricia. They had five children. the youngest 19. Brophy worked two jobs—he was a fire fighter and an emergency medical technician. A vigorous man, Brophy enjoyed deer hunting and fishing, and he owned a camp on Great Moose Lake in Hartland, Maine.

Brophy had never made out a Living Will, but he had forcefully expressed his views on what kind of life he did *not* want if he should become incompetent. The following is from the findings of fact by the trial judge of the Probate and Family Court Department, Norfolk division (October 2, 1985):

Approximately ten years ago, Brophy and his wife discussed the Karen Ann Quinlan case. During this discussion, Brophy told his wife: “I don't want ever to be on a life-support system. No way do I want to live like that; that is not living.”

Brophy had a favorite saying about life, which he expressed to his wife: “When your ticket is punched, it is punched.”

Approximately five to six years ago, Brophy and his partner dragged a man with excessive burns from a burning truck and transported him to a Boston hospital. The victim lived approximately two to three months. The Town of Easton gave Brophy and his partner a commendation for bravery. Brophy subsequently threw the commendation into the waste basket and explained to his wife: “I should have been five minutes later. It would have been all over for him.”

In March of 1983, approximately a week prior to [Brophy's] illness, a teenage pedestrian was struck by a motor vehicle in Brophy's community. The teenager survived two or three days on a life-support system. In discussing this incident, Brophy told his wife: “No way, don't ever let that happen to me. No way.”

At about midnight on March 22, 1983, Paul Brophy told his wife he had a terrible “splitting” headache. He rolled over in bed and lost consciousness. Unable to waken him, Patricia Brophy called the Easton Fire Department and he was taken to the Goddard Hospital in Stoughton. On the way, Brophy regained consciousness.

The next day, one of his children, Karen Olson, visited him at the hospital. According to the subsequent court record, “When Brophy pulled himself up to a half-sitting position in order to kiss his daughter, she scolded him for not lying still. On that occasion, Brophy told his daughter, “If I can’t sit up to kiss one of my beautiful daughters, I may as well be six feet under.”

A CAT scan disclosed a rupture of a blood vessel at the base of Brophy’s brain, a basilar artery aneurysm. On April 6, 1983, having been transferred to the intensive care unit of the New England Medical Center, Brophy was operated on and a clip was inserted across the basilar aneurysm.

Following that operation, said the court, Paul Brophy never regained consciousness.

On June 28, 1983, Brophy was transferred to New England Sinai Hospital, a chronic care hospital in Stoughton, Massachusetts. For nearly four weeks, the patient received intensive physical and speech therapy, but he showed no response, and the therapy was discontinued.

On July 7, 1983, during a neurological consultation, Brophy did not respond to any verbal stimuli, but when something pained him, his right eye opened at times. When pressure was put on his breastbone, there was a “slight but appropriate movement in both upper extremities.” A pin prick to the soles of his feet resulted in the withdrawal of both feet. These responses may have been reflexive, rather than cognitive.

In August 1983, Brophy contracted pneumonia, running a 104-degree temperature. The hospital asked his wife what she wanted done if her husband were to experience cardiac arrest. Should everything possible be tried to revive him? Or should no extraordinary means be used?

Patricia Brophy talked to her children, and then told the hospital to enter a do-not-resuscitate order (a DNR) on Brophy’s chart. If he suffered a cardiac arrest, nature would take its course. The hospital agreed to abide by her wishes. Both agreed Brophy would be kept warm and comfortable, and provided with food and water.

When intravenous feeding was no longer possible, Mrs. Brophy authorized a surgical procedure—a tube gastrostomy—by which a hole is created through the abdominal wall into the stomach. On December 21, 1983, through that hole, a gastrostomy tube (a G tube) was inserted, and the tube provided Brophy with nutrition and hydration directly into his stomach.

Later, when Mrs. Brophy changed her mind about giving him food and water, the courts had to decide whether this G tube was to continue to function.

As a friend of mine, a Massachusetts physician, put it, Paul Brophy had become “totally dependent on society and society’s values.”

The trial judge, David Kopelman—during the hearing on whether the G tube was to be removed—declared, as fact:

All of the medical experts agree, and I so find, that Brophy is not brain dead. . . . The three basic criteria for brain death are:

- a) unresponsiveness to normally painful stimuli;
- b) absence of spontaneous movements or breathing; and
- c) the absence of reflexes.

But, the court went on, Brophy has indeed “suffered serious and irreversible damage to his brain.” Relying on examinations by two neurologists brought in by Mrs. Brophy, the trial court ruled that Paul Brophy, though not brain dead, was in “a chronic persistent vegetative state.” That is, the patient:

- a) shows no evidence of verbal or nonverbal communication;
- b) demonstrates no purposeful movement or motor ability;
- c) is unable to interact purposefully with stimulation provided by his environment;
- d) is unable to provide for his own basic needs;
- e) demonstrates all of the above for longer than three months.

The two neurologists asked to testify by Patricia Brophy predicted that it was highly unlikely that Paul Brophy would ever regain the cognitive ability to purposefully interact with his environment.

Another perspective was that of Dr. John F. Sullivan, former chief of neurology at New England Medical Center. I am told that Dr. Sullivan has long been known as a “doctor’s doctor”—the kind of neurologist to whom referrals are made even by specialists with regard to cases whose etiology they’re not sure of. Sullivan testified that Paul Brophy, rather than being in a “persistent vegetative state,” may instead have been suffering from “Locked-In Syndrome.”

(As defined by Dr. Dana Johnson, Associate Professor of Medicine at the University of Minnesota, “Locked-In Syndrome” is “caused by a destructive lesion in the brainstem which interrupts motor pathways to the extremities and the muscles involved in speech. These individuals are intellectually aware. . . . However, they are completely unable to vocalize their thoughts, wants and needs.”

Dr. Sullivan believed that Paul Brophy may have had some sensory recognition of what was going on around him, even though he couldn’t communicate.

The trial judge did not agree, but did state that “Apart from the injury to his brain, Brophy’s general state of health is relatively good. He is not terminally ill, and he is not in danger of imminent death from any underlying medical illness. He is able to breathe entirely on his own, without assistance from a respirator or other mechanical life-support system.”

Patricia Brophy, who had been a nurse—and is currently a nurse again—

visited her husband continually. (“I still thought there was some bond between us,” she told Peter Anderson of the *Boston Globe*. “I could never just leave him there.”)

A year after the surgery on her husband, Patricia Brophy, convinced her husband’s “life was over,” asked New England Sinai Hospital to remove the G tube that was providing her husband with nutrition and hydration. She had first gone to Father John Paris, the ethicist from Holy Cross College, and he had said to her, according to the *Boston Globe*: “Are you convinced Paul’s condition is irreversible? Are you convinced he would not want to be maintained in this condition? Are you convinced the family is agreed on this?” When she said, “Yes,” to all three questions, Father Paris said, “What’s the problem?”

But there *was* a problem. Paul Brophy’s attending physician refused to comply with Mrs. Brophy’s request, nor would the hospital’s Physician-in-Chief. Nor would the medical and nursing staff. They would not participate, they said, in any willful taking of the life of a human being.

So Patricia Brophy went to court. The trial judge, David Kopelman, said it was okay to have a do-not-resuscitate order in Brophy’s file. It was also okay to have a “non-aggressive treatment plan” whereby life-threatening infections would not receive aggressive and invasive treatment. But the judge refused to order the denial of food and water—even though he acknowledged that Brophy, had he been competent, would have wanted them removed.

Next: What did the judge hear during the trial to make him decide as he did? What did the judges of Massachusetts’ highest court then go on to decide? And why?

VI. Come Sweet Death

He is, in the last analysis, to be killed because his presence is inconvenient and costly to society and a source of anguish to his relatives.

—DAVID B. WILSON, columnist, *Boston Globe*, September 30, 1986

My husband is not the man I married. . . . In essence his life is over. . . . There is no quality of life.

—PATRICIA BROPHY, testifying before the Trial Court, Probate and Family Court Department, Massachusetts, 1986

We start off with dispatching the terminally ill and the hopelessly comatose, and then perhaps our guidelines might be extended to the severely senile, the very old and decrepit and maybe even young, profoundly retarded children.

—DR. MARK SIEGLER, director, the Center of Clinical Ethics, University of Chicago, *Time*, March 31, 1986

The trial judge had decided that Paul Brophy—a fireman who had suffered a ruptured blood vessel at the base of the brain—was in a persistent vegetative state. There had been medical testimony questioning that diagnosis, but the judge had been convinced by the neurologists called into the case by Patricia Brophy, who wanted her husband’s feeding tube cut off so that he could die with dignity.

The judge had concluded that the chances of Paul Brophy ever being able to interact meaningfully with the world were practically nonexistent. But he also noted that Brophy was by no means imminently dying, and if the feeding tube were to stay in place, he might live another 30 years or more. Furthermore, the tube was not causing him any pain or discomfort.

There was another thing the judge wanted to know. If he ruled that all nutrition and hydration should be stopped, what would happen to Paul Brophy? He would die within five days to three weeks. But how would he die?

In his findings of fact, the trial judge, David Kopelman, listed the effects “Brophy’s body would be likely to experience” if he were to be deprived of all nutrition and hydration.

This is what the judge found out:

- a) His mouth would dry out and become caked or coated with thick material.
- b) His lips would become parched and cracked or fissured.
- c) His tongue would become swollen and might crack.
- d) His eyes would sink back into their orbits.
- e) His cheeks would become hollow.
- f) The mucosa (lining) of his nose might crack and cause his nose to bleed.
- g) His skin would hang loose on his body and become dry and scaly.
- h) His urine would become highly concentrated, causing burning of the bladder.
- I) The lining of his stomach would dry out, causing dry heaves and vomiting.
- j) He would develop hyperthermia, a very high body temperature.
- k) His brain cells would begin drying out, causing convulsions.
- l) His respiratory tract would dry out, giving rise to very thick secretions, which could plug his lungs and cause death.
- m) Eventually his major organs would fail, including his lungs, heart and brain.

This information disturbed the judge. So did testimony by Dr. Richard Field, the chief of staff at New England Sinai Hospital, where Paul Brophy was a patient. Dr. Field was asked if he had ever seen a person dehydrate and starve to death.

Yes, he had. When?

During World War II, Dr. Field explained, he had been attached to an infantry division, and it was his division that liberated Dachau.

The courtroom became very quiet.

“I saw,” Dr. Field said, “literally thousands of people who had been subject to both dehydration and starvation—both dead and dying . . . Bringing about death through dehydration and starvation is a barbaric and savage way to induce death, and as such is cruel and abusive and not conscionable.”

Dr. Field made it clear that if the court ordered him to remove Paul Brophy’s feeding tube, he would, in conscience, refuse. And so would the other doctors and the nurses at New England Sinai Hospital. “This would be done,” he testified, “with the willful intention of producing a man’s death, and for no other reason.”

It is killing, Dr. Field said in answer to a question by Mrs. Brophy’s lawyer, Frank Reardon.

On the other hand, physicians supporting Patricia Brophy testified that it was entirely ethical to remove food and water from a patient in Paul Brophy’s condition. Dr. Joseph Alpert, director of the cardiovascular unit at the University of Massachusetts Medical Center in Worcester, said there was nothing cruel about removing the feeding tube. He added that his own hospital’s policy was to cut off nutrition tubes when appropriate.

Then there was this exchange—as reported in the May 24, 1985 *Quincy Patriot Ledger*—between Patricia Brophy’s attorney and Dr. Alpert.

Reardon asked Alpert if he himself had ever removed a feeding tube.

“I have—in patients who are hopelessly or terminally ill . . . on many occasions. The process is very simple. The food or fluids are administered by gravity or by a small pump. One just stops the flow.”

“Eventually,” Frank Reardon asked, “the patient will die, is that correct?”

“Yes, that’s correct,” said Dr. Alpert. “But the cause of death is the patient’s underlying cause of illness. We do not look at the final blow.”

Listen again to that last line. Let it reverberate down the slippery slope of euthanasia in America.

One part of Dr. Alpert’s testimony struck some observers as particularly, chillingly, revealing. It’s in Peter Anderson’s “The Final Days of Paul Brophy,” *Boston Globe Magazine*, January 25, 1987:

I might add that almost always, these kinds of cases don’t end up in courtrooms. They get decided day in and day out, almost on a daily basis, in every hospital in the United States . . . It is very common for one to not administer any further medicine, to stop intravenous infusions, to stop tube feedings. . . .

Whatever happened to due process of law, especially when life-and-death decisions are being made? Are physicians and hospitals—and families of the patient for that matter—allowed to make such decisions outside the Constitution?

Peter Gubellini, the court-appointed attorney trying to keep Paul Brophy alive, was outraged at what Dr. Alpert disclosed had been going on inside hospital walls. “No court in this commonwealth,” Gubellini said, “ever sanctioned the taking of a human life by cessation of food and water.”

So, did anyone perform a citizen’s arrest of Dr. Alpert? Don’t be silly. Anyway, when the Brophy case was over, the highest court in that state had at last sanctioned the taking of a human life by cessation of food and water. As has New Jersey, among other states. And in New York, Gov. Cuomo’s State Task Force on Life and the Law will release a report this fall on the withdrawal and withholding of life-sustaining treatment. I have not seen it yet, and I hope I’m wrong, but I will not be surprised if the New York Task Force goes along with the current euthanasia tidal wave by recommending that it’s okay to cut off food and water—as forms of “medical treatment”—from certain patients.

In the Massachusetts trial court, Dr. Lajos Koncz, Paul Brophy’s attending physician, vigorously opposed the removal of his patient’s feeding tube. “Nutrition is not treatment, because I don’t think you would characterize a mother who is feeding her baby, either through breast or with spoon, as treating that baby.”

A hopeless sentimentalist, Dr. Koncz. He will soon be obsolete in the new world of medicine where Bach’s “Come Sweet Death” will be piped into selected hospital rooms, and certain patients will be given handsomely printed booklets on one’s duty to die to make room for the younger generation. As for the incompetent patients, they will not stay in their beds long.

The trial judge in Massachusetts, having found out what it is like to die of dehydration and starvation, had one more question. Would Paul Brophy be able to *feel* any of the horrible things going on inside his body? The neurologists who testified for Brophy’s wife said that since he was in a persistent vegetative state, he would not have the capacity to experience pain and suffering.

Father John Paris, the medical ethicist from Holy Cross College—and a witness for Mrs. Brophy—said sardonically, “Some people are getting very, very excited about starving someone to death.”

Dr. John F. Sullivan, a neurologist of considerable standing, wasn’t even sure that Brophy was in a persistent vegetative state. As for how Brophy would take starvation, Dr. Sullivan testified, “I can’t rule out his ability to have cognitive function or to experience pain.”

Sullivan may be prejudiced, however. Years ago, he was assigned to a hospital ward at Buchenwald 24 hours after the Americans liberated the death camp. Somehow Dr. Sullivan has not been able to forget the experience of seeing all

those dehydrated Jews.

Dr. Richard Field, chief of staff at New England Sinai Hospital, said he could not give an opinion on whether Brophy would suffer, or how much. Elaine Moriarty, the lawyer for New England Sinai, said that the other physicians at the hospital also “do not know whether Brophy would feel pain or discomfort or would otherwise suffer from death in this manner, *but the possibility is not foreclosed.*” (Emphasis added.)

I decided to ask the opinion of someone removed from the case—one of the country’s preeminent physicians and medical educators. Dr. Edmund Pellegrino is the director of the Kennedy Institute of Ethics at Georgetown University, and he is also John Carroll Professor of Medicine and Medical Humanities at Georgetown University Medical Center, Washington.

“I am not sure a patient in that state does not suffer,” Dr. Pellegrino said. “I can tell you that I have had a few patients who have recovered from such a condition. I mean a so-called comatose, persistent vegetative state.”

Dr. Pellegrino cautioned that the definition of this condition is not very precise or agreed on in medicine.

(Arguing for Paul Brophy, his lawyer, Paul Gubellini, who has become well-versed in medical matters, emphasized that “the term PVS [persistent vegetative state] is a relatively new medical term; PVS is difficult to diagnose with certainty; the term itself means different things to different neurologists and doctors.” As was evident at the trial.)

Those few of his patients who came out of a persistent vegetative state, Dr. Edmund Pellegrino told me, “had memory. They could tell me what happened during that time. Experienced clinicians will tell you the same thing.”

Accordingly, Dr. Pellegrino refused to say that it would have been impossible for Paul Brophy not to feel pain, not to be aware of the disintegration of his body after all food and hydration had been taken from him.

Well, we will never know what Paul Brophy felt, if anything, because he is dead. The trial judge decided that his feeding tube could not be withdrawn; but a bitterly divided Massachusetts Supreme Judicial Court reversed that judge and gave Patricia Brophy the power to remove her husband from New England Sinai Hospital to another institution which would finally close the books.

But the case, as we shall see, remains very much alive.

VII. RX: No Food/No Water

On March 8, 1941, the Catholic bishop, Clemens von Galen of Münster, in Westphalia, spoke from the pulpit against the “euthanasia” action.

He said:

“These unfortunate patients must die because, according to the judgment of some doctor or the expert opinion of some commission, they have become ‘unworthy’ to live. . . . Who, then, from now on, could still have confidence in a physician?”

—Dr. Frederick Wertham, *A Sign for Cain*, Macmillan (1966) reprinted in *The German Euthanasia Program*, Hayes Publishing Company, 1976.

It will take time, but society must come to accept that merely individual existence is meaningless when compared to the interest of the whole. . . . Once upon a time, barbarians eliminated all unfit lives; now we preserve unfit lives. As society progresses in a spiral, we will again come to see the higher morality of destroying the unfit.

—Karl Binding, Professor of Law and Philosophy, co-author of *Permitting the Destruction of Unworthy Life Part I*, Germany, 1920

The whole undertaking went by different designations: “help for the dying,” “mercy death,” “mercy killing,” “destruction of life devoid of value,” “mercy action.” . . .

[The killing] was carried out by individual institutions and individual doctors. . . . [Among the] methods employed [was the] deliberate withdrawal of food. . . . This was called euthanasia too. “Euthanasia” by starvation. Such methods had the advantage of more discretion: patients who were destroyed in this way could be more easily counted as “natural deaths.”

—Dr. Frederick Wertham, (*ibid.*)

The Hastings Center in Briarcliff Manor, New York, may be the most influential of all the American think tanks specializing in the new secular religion, bioethics. As defined in the just released unabridged second edition of *The Random House Dictionary of the English Language*, this misty discipline is defined as: “a field of study concerned with the ethical and philosophical implications of cer-

tain biological and medical procedures, technologies, and treatments [such] as organ transplants, genetic engineering, and care of the mentally ill.”

The term, bioethics, is only about 15 years old, but its priesthood has been steadily growing. It is wise to pay attention to what the bioethicists do and say because one day, you may lose your life as the result of a policy guide designed by one or more of their number. Some bioethicists are concerned with preserving life, but the majority of them have become skilled in finding reasons for ending lives. They see themselves as compassionate but practical.

Many of these bioethicists are in the tradition of the distinguished German psychiatrist, Dr. Alfred Hoche, co-author of the 1920 book, *Permitting the Destruction of Unworthy Life*, who boldly declared: “We ask openly, *Are there human lives which have no value to society or to their bearer?*”

The Hastings Center would not put the question in quite those terms, but those who do will find much of use in the Center’s new report, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*.

Susan Wolf, director of the project that resulted in this report, describes it as offering “comprehensive ethical guidelines” in these matters. The guidelines, she notes, have no legally binding authority, but the recommendations “may be incorporated into statutes, judicial decisions, administrative rules, or institutional policies.”

The Hastings guidelines surely will influence many judges, legislatures, and institutions that seek authoritative advice as to how to handle these “biologically tenacious” patients who will not die when they should. For the past three years, I have been reading court decisions from states round the country on speeding the deaths of certain patients. In most of those opinions, judges quote gratefully from the 1983 report, *Deciding to Forego Life-Sustaining Treatment: Ethical and Medical Legal Issues on Treatment Decisions*, by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. It was a pioneering study in how to end lives whose “quality” is not worth preserving.

Judges and legislators, moreover, quote even more frequently from the 1986 decision by the American Medical Association that says physicians may ethically remove nutrition and hydration from certain patients “even if death is not imminent.”

Now, the Hastings Center’s *Guidelines* will buttress new court decisions and statutes on when it’s okay to withdraw treatment so that a patient will die. Or rather, when it is okay to kill a patient by not treating him or her any more.

In this column, I shall not examine all of the Hastings guidelines, being most concerned at this stage of this series by the effect on the society as a whole when physicians, ethicists, and judges decide that patients can be deprived of food and water.

The section on starvation in the Hastings report is not called that at all. The title is: “Guidelines on Medical Procedures for Supplying Nutrition and Hydration.” These bioethicists, as we shall see, have gardens in which they cultivate only euphemisms.

We are told that when food and water are supplied artificially, as through tubes, they are “medical interventions,” like respirators. And therefore, “the standards to be used for decisions concerning termination of these procedures are essentially those that apply for the termination of other forms of treatment.”

It’s very clever. If food and water are defined as being in the same category as respirators, dialysis, or some other formidable technological means of keeping someone alive, then food and water are thereby considered “extraordinary” means of medical treatment.

The Hastings folk say they do not recognize the distinction between “ordinary” and “extraordinary” means of treatment. But in reversing millennia of human experience by ruling food and water as no longer ordinary and basic to patient care, the Hastings cadre has indeed made food and water “extraordinary.” That is, surely respirators are not “ordinary,” and since nutrition and hydration are now on the same level as advanced medical technology, they are not “ordinary” either, and it’s no big deal to dispense with them.

The thrust of the section on food and water is that under certain conditions, they can be denied to the patient. “Denied” is not used; it’s too honest a word. “Discontinue,” for instance, is less disturbing.

In a particularly broad guideline that is a prelude to ending nutrition and hydration, the Hastings bioethicists say that “all invasive procedures for supplying nutrition and hydration” not only require the patient’s or surrogate’s consent but can be *discontinued* if the patient or surrogate so decides.

Most of the cases explored in this series, and in the courts, concern patients without the capacity to make such a decision. So it’s up to a relative to decide. Or if the patient has no family, the decision is made by a friend designated beforehand as a surrogate.

But that was the problem in the Paul Brophy case, and in Ellen Jobes’ and in many other cases that involved “invasive” feeding tubes. (Nearly all artificial feeding is “invasive,” one way or another.) The problem is: should a surrogate have the power to kill a patient by taking away food and water?

Increasingly, the courts say “Yes”—with the encouragement of the right-to-die societies and such institutions as the Hastings Center, which can also be described as a right-to-die society. And increasingly, the courts are both blurring and broadening the categories of patients who can be killed by “substituted judgments” of surrogates. A recent decision by Arizona Supreme Court—rigorously citing the 1983 President’s Commission for the Study of Ethical Problems in Medicine and the 1986 AMA ruling on the removal of food and

water—indicates what’s coming.

In the case of Mildred Rasmussen, the Arizona Supreme Court’s language allowing the removal of life-saving treatment from patients who are incompetent is so expansive that it can reach all legal incompetents, including the mentally ill and the mentally retarded. Their surrogates may now be able to starve such patients to death. And like the Hastings Center, the Chief Justice, Frank Gordon, Jr., emphasized that the court makes no distinction between “ordinary” and “extraordinary” treatment. That is, between “mechanical breathing devices” and “mechanical feeding devices.”

The Hastings *Guidelines*, for all their caveats, are broad enough to get a lot of people killed in the years to come. Dissenting from the food-and-water section of the guidelines, Leslie Steven Rothenberg, a lawyer and a clinical ethicist in Los Angeles, says in the appendix to this report that the *only* patients from whom food and water should be withdrawn are those “whose death is expected within a few days, or for whom nutrition cannot be provided successfully because they have lost the ability to metabolize.”

Dr. Rothenberg also dissented from some of the other conclusions of the report about ending treatment of certain kinds of patients:

“I fear these *Guidelines*, if widely endorsed, may be used to give a moral ‘imprimatur’ to undertreating or failing to treat persons with disabilities; unconscious persons for whom accurate prognoses are not yet obtainable; elderly patients with severe dementia; and others whose treatment is not believed—to use the language [of another part of the report] ‘costworthy.’” (Keep that word, “costworthy”, in mind, as it relates to preserving human life.)

That is a powerful dissent. Yet, although there were 20 prominent physicians, professors, and ethicists who were members of that Hastings project, Leslie Steven Rothenberg was the *sole* dissenter on all those fundamental grounds. And there was only one other.

One member of the project, Daniel Callahan, director of the Hastings Center, wrote a compelling article in the October 1983 issue of *The Hastings Center Report*. He said that the reemergence of the debate on whether to take food and water away from certain categories of patients had come about “because a denial of nutrition may in the long run become the only effective way to make certain that a large number of biologically tenacious patients actually die.

“Given the increasingly large pool of superannuated, chronically ill, physically marginal elderly,” Callahan continued, “it could well become the nontreatment of choice. Second, because we have now become sufficiently habituated to the idea of turning off a respirator, we are psychologically prepared to go one step further. ”

Callahan did not want to take that step. He asked: “Is it an extravagant exercise of the imagination to envision a time in the future when” it is decided that “feeding does an irreversibly comatose patient no good; therefore it must be stopped?”

That time, of course, has come—for the late Nancy Ellen Jobes, Paul Brophy, et al. In 1983, Callahan tried to prevent its arrival by arguing that “the feeding of the hungry, whether because they are poor or because they are physically unable to feed themselves, is the most fundamental of all human relationships. It is the perfect symbol of the fact that human life is inescapably social and communal. We cannot live at all unless others are prepared to give us food and water when we need them. . . .

“It is a most dangerous business to tamper with, or adulterate, so enduring and central a moral emotion.”

In the newly released *Hastings Guidelines on Terminal Treatment*, including food and water, there is no dissent by Daniel Callahan, who was a member of this project. He is silent about what happens to a society when a highly respectable group of its healers and ethicists gather together and decide that it is no longer a dangerous business to starve people to death.

Fifty years ago, a number of the finest practitioners of German medicine and law could have been members of that Hastings Project. They had already devised one of their own.

The Legacy of Terri Schiavo

The Disabled Sound the Alarm for the Nonreligious

During the prolonged, extensive media coverage of the fierce battle this past spring over whether Terri Schiavo should live or die, almost entirely ignored was the insistent presence of individuals and organizations who were most personally concerned with both the outcome of the conflict and its legacy. Attention was continually focused on the Christian Right, who rallied for Schiavo's right to live-traditional Catholics, Protestant evangelicals, and religious proliferers. (Not all proliferers are religious, to which I can attest.) Overlooked, however, were the twenty-nine national disability-rights organizations that filed legal briefs and lobbied Congress to demonstrate that Terri Schiavo's was a disability-rights case, not a right-to-die case. They included the National Spinal Cord Injury Association; the National Down Syndrome Congress; the World Association of Persons with Disabilities; and the largest American assembly of disability-rights activists, the American Association of People with Disabilities. I have been reporting on disability rights for more than thirty years, and I have learned that many of these groups are determinedly secular and take care to not be linked with religious partisans or proliferers. Many disability-rights activists are pro-choice.

One such advocate is Mary Johnson, who runs an influential Web site linking many of these disability-rights groups (www.raggededgemagazine.com). She stated the concerns of the disabled brought to the fore by the Schiavo case: This isn't about Terri Schiavo anymore. . . . The danger faced by "incapacitated" or non-communicative persons-people who have been declared "incompetent" and their legal rights assigned to a "guardian"¹-has been worrying disability rights activists for years. It is not about the "right to life"-it is about equal protection of the law. Over a dozen national disability groups have repeatedly urged Constitutional review of cases like Schiavo's.

Another writer who has drawn attention to the issue is Laura Hershey, who uses a ventilator. She wrote (the-nation.com, April 14, "Killed by Prejudice") that when she is hospitalized, she makes sure to write "Do resuscitate!" on all her medical charts because, the last time she was hospitalized, three hospital staffers assumed that, since she was disabled, her chart had to include a do-not-resuscitate order. In addition to "my disability identity," she writes, "I'm a lesbian feminist. I'm a secular thinker. . . . I abhor the fundamentalist religious movement's selective advocacy of some rights for some people." Tellingly, she adds: Yet many of my usual allies, people who support civil rights for other

minority groups, have trouble embracing the rights of people with severe disabilities. . . . To my knowledge, no progressive or feminist group has tried to understand or address the injustices involved in this case of spousal and medical violence against a disabled woman (Terri Schiavo).

Many disability-rights advocates feel abandoned by the American Civil Liberties Union (ACLU). Despite the egregious conflicts of interest of Terri Schiavo's husband and guardian, Michael Schiavo (see my article, "Terri Schiavo: Judicial Murder," Village Voice, March 29, 2005), the ACLU was cocounsel in some of Michael Schiavo's court actions to remove the feeding tube of this forty-one-year-old woman who was not brain dead or comatose and breathed naturally on her own. Nor, according to neurologists I interviewed, was she in a persistent vegetative state.

Last November, Andrew J. Imparato, head of the American Association of People with Disabilities (on the opposite side of the ACLU in this case), testified before the Senate Subcommittee on Science, Technology, and Space on the rising dangers to the disabled of prenatal genetic testing technology. He spoke of the fear of many disabled about the return of eugenics:

When we start devaluing the lives of people with disabilities, we don't know where that's going to stop. You also need to take into account the financial implications of all of this. We have an economy that is not doing well as it once was and . . . one way to save money is to make it easier for people with disabilities to die.

Since the death of Terri Schiavo, disability-rights organizations have accelerated working with members of Congress to formulate legislation that will protect the Fourteenth Amendment rights of the disabled to due process and equal protection of the laws. One of the most liberal members of the Senate, Tom Harkin (D-Iowa), insists that "Where someone is incapacitated and their life support can be taken away . . . it is appropriate-where there is a dispute-that a federal court come in, outside of the state's jurisdiction, like we do in habeas corpus situations-and review it."

Having reported on the Terri Schiavo case for the past two and a half years-and having read all of the transcripts of court hearings-I am certain of one dimension of this case: Terri Schiavo was fatally denied due process because all the appellate courts, state and federal, relied wholly on the rigid misunderstanding of the central facts of the case by one Florida Circuit judge, George Greer. If this had been a case of a prisoner on death row with an execution date, the ACLU and a good many liberals would have demanded habeas review, from the beginning, of all the facts in the case.

Speaking with the disabled over the years, I have been told, "It's worth keep-

ing in mind that you are only temporarily able. You could unexpectedly, suddenly, become one of us.” Also heeding that warning was Dick Rogers of the *San Francisco Chronicle*, whose March 29, 2005, column was headed: “Schiavo’s Story Is about Us All.” Pat Anderson, a former lawyer for Terri Schiavo’s parents in their daughter’s case, has resoundingly made clear why Terri Schiavo’s story is about us all: “Euthanasia in America now has a name—and a face.”

Adding resonance to her point is the increasing refusal of intensive care by hospitals whose physicians and bioethics committees decide that it is “futile” to continue to treat those patients whose “quality of life” is so tenuous, they say, no further treatment is required. In “The Culture of Death: Who Will Decide When You Should Die?” (*Village Voice*, December 1, 2003), I quoted Nancy Valko, a nurse whose specialties include oncology, kidney machines, trauma, cardiac and cancer care, and patients who may or may not be in a persistent vegetative state (that diagnosis has a considerable error rate). Valko, who works in an intensive care unit in a St. Louis county hospital, also gives workshops on medical ethics and writes extensively on disability rights. One of her articles, “Futility Policies and the Duty to Die,” reported: This theory that [some lives are no longer worth living] has now evolved into “futile care” policies at hospitals in Houston, Des Moines, California and many other areas. Even Catholic hospitals are becoming involved. . . . Thus, the “right to die” becomes “the duty to die,” with futile care policies offering death as the only “choice.” . . . A poor prognosis, which can be erroneous and is seldom precise, will become a death sentence.

Two years ago, Terri Schiavo’s father, Bob Schindler, aware of the increasing odds against his daughter, said: “We pay great lip service in this country to disability rights, but as the degree of a person’s disability increases, the level of legal protection that person receives decreases.”

Agreeing, I turn, as I often do, to Wesley Smith, author of *Culture of Death: The Assault on Medical Ethics in America* (Encounter Books) for a start on increasing the legal levels of protection for the voiceless and the otherwise acutely vulnerable of the 56 million American children and adults with disabilities. In the April 11, 2005, *Weekly Standard*, Smith advised that States need to review their laws of informed consent and refusal of medical treatment to ensure that casual conversations—the basis for Terri’s death order [according to her husband and disputed, under oath, by one of her close friends]—are never again deemed to be the legal equivalent of a well-thought-out, written advance directive [preferably a durable power of attorney]. We don’t permit the property of the deceased to be distributed on their oral statements. Surely human lives deserve as much protection. He adds:

If people don't want feeding tubes if they become profoundly incapacitated, the law permits them to refuse such care [and other treatment]. That isn't going to change. But if that is their desire, they have the responsibility to make sure that such wishes are put in a legally binding document.

Absent that, the law should require the courts in contested cases to give every reasonable benefit of the doubt to sustaining life and not causing death by dehydration.

As for the rising doctrine of futility noncare in American hospitals, Smith warns that "unless people object strongly to this duty to die . . . and unless [federal] legislatures take active steps to intervene, this new and deadly game of 'Doctor Knows Best' will be coming soon to a hospital near you."

You may have noticed that God has not appeared in this article. Many who have leaped into faith do work against the culture of death as it envelops the disabled, but this is far from their exclusive crusade. Secularists are a permanent, vital force in this battle-in part out of our own self-interest. For example, I take seriously Tom Harkins's warning about "guardians" of the incapacitated who feel "that their ward is as good as dead, better off dead-or that the guardian himself or herself would be better off without the ward." I hereby state on this public record that I will not consent to my "duty to die." The disability-rights community, like all activists groups, is not monolithic. But the one phrase that all of their members dread hearing is "quality of life." Some have told me of their parents telling them how, when their disabled child was born, or soon after, physicians counseled them to "let the child die" because his or her "quality of life" would not make that life worth living. From some of these disability rightists, I first learned of Dr. Leo Alexander. An Austrian-born professor of psychiatric medicine at Tufts Medical School, he had served as an expert at the Nuremberg trials, having interviewed the German physicians who implemented Hitler's pre-Holocaust euthanasia program. Dr. Alexander's subsequent article in the July 14, 1949, issue of the *New England Journal of Medicine*, "Medical Science Under Dictatorship," is central to understanding the historical root of the "quality of life" debate in this country that has quickened since the judicial death by dehydration of Terri Schiavo.

Dr. Alexander emphasized that whatever proportions the [Nazis'] crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. At first, there was merely a subtle shift in emphasis in the basic attitude of physicians. It started with the acceptance, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived.

This shift in emphasis began before Hitler came to power. In 1920 Karl Binding, a prominent German lawyer, and Alfred Hoche, a distinguished forensic

psychiatrist, wrote a brief but influential book, *The Permission to Destroy Life Unworthy of Life*. In *The Coming of the Third Reich*, Richard Evans notes that “They emphasized that the incurable ill and the mentally retarded were costing millions of marks and taking up thousands of much-needed hospital beds. So doctors should be allowed to put them to death.”

When Hitler came to power, many German doctors were ready to obey Hitler’s directive to rid the nation of costly, unproductive “useless eaters.” Before the Holocaust, “worthless” Germans were summarily eliminated by the Nazis. As an October 1, 2003, Associated Press story reported: A new study reveals Nazi Germany killed at least 200,000 people because of their disabilities—people deemed physically inferior—said a report compiled by Germany’s Federal Archive. Researchers found evidence that doctors and hospital staff used gas, drugs and starvation to kill disabled men, women and children at medical facilities in Germany, Austria, Poland, and the Czech Republic. Concluding his 1949 *New England Journal of Medicine* article, Dr. Alexander emphasized, “It is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received an impetus was the attitude toward the non-rehabilitable sick.” (Emphasis added.)

Shortly before he died, Dr. Alexander read an article in the April 12, 1984, *New England Journal of Medicine* signed by ten doctors from such prestigious institutions as Harvard Medical School, Johns Hopkins University School of Medicine, and the University of Virginia Medical Center titled “The Physicians’ Responsibility Toward Hopelessly Ill Patients.” These healers advocated the withdrawal of artificially administered nutritional support—including fluids—from various kinds of patients, including those in “a persistent vegetative state,” without mentioning how problematic the diagnosis of that state was and continues to be.

These distinguished physicians claimed it was “morally justifiable” when a patient is in a persistent vegetative state, or is otherwise nonrehabilitative, to withhold antibiotics, feeding tubes, and hydration, “as well as other forms of life-sustaining treatment, allowing the patient to die.” A less Orwellian newspeak way of putting that would have been: “allowing the caregiver to kill the patient.” After he’d finished reading the article, Dr. Alexander, depressed, told a friend, “It is much like Germany in the ’20s and ’30s. The barriers against killing are coming down.” And indeed they have been coming down, as indicated by the continually growing doctrine of “futility” noncare in American hospitals, hospices, and bioethics committees.

As disability-rights activists mobilize to alert legislators and the rest of us to the legitimizing of euthanasia in this country for those whose “quality of life” makes them useless eaters, some of them point to a widely publicized letter that has long resonated within the disability-rights community. The letter was writ-

ten in reaction to the increasing euthanizing of infants with Down Syndrome and other signs of inferior “quality of life.” The letter by Sondra Diamond appeared in the December 3, 1973, *Newsweek*.

Due to severe brain damage incurred at birth, I am unable to dress myself, toilet myself, or write; my secretary is typing this letter. Many thousands of dollars had to be spent on my rehabilitation and education in order for me to reach my present professional status as Counseling Psychologist.

My parents were . . . told 35 years ago that there was little or no hope of achieving meaningful “humanhood” for their daughter. . . . Instead of changing the laws to make it legal to weed out us “vegetables,” let us change the laws so that we may receive quality in medical care, education, and freedom to live as full and productive lives as our potentials allow.

On the other hand, in the July 1983 issue of *Pediatrics*, the official journal of the American Academy of Pediatrics, Professor Peter Singer—in an article entitled “Sanctity of Life” or “Quality of Life”—wrote:

If we compare a severely defective human infant with a nonhuman animal, a dog, a pig, for example, we will often find the nonhuman to have superior capacities, both actual and potential, for rationality, self-consciousness, communication, and anything else that can plausibly be considered morally significant. Only the fact that the defective infant is a member of the species *homo sapiens*, leads it to be treated differently from the dog or pig.

At the time Professor Singer’s article was published, and increasingly since, infants whose “quality of life” is deemed not worth preserving have been euthanized, without, of course, their having had the opportunity to provide a living will or a durable power of attorney stating their wishes.

The questions before us, as part of the legacy of Terri Schiavo, are the crucial definitions of “quality of life,” “futility,” and “morally justifiable” with regard to the future of the disabled, from birth on. How this debate is resolved should be more than passing interest to those of us who are only temporarily able.

The following is excerpted from the first Great Defender of Life Dinner, 2003. Mary O'Connor Ward, sister of John Cardinal O'Connor, read Mr. Hentoff's tribute to J.P. from the podium.

The Legacy of James P. McFadden

Mary O'Connor Ward:

As some of you may be aware, Nat Hentoff was expected to be here tonight, but circumstances changed. Although he is unable to be here personally to pay tribute to his good and dear friend, I have been asked to present his remarks to you. I feel so proud and privileged to do so, and hope that I can do his words justice. He has entitled this "The Legacy of James P. McFadden."

Remembering the quick, penetrating wit of J.P. McFadden, I was thinking of him when I saw, in *Lifespan News*, a Michigan pro-life newspaper, a report of a Planned Parenthood poster contest on the theme, "Every Choice Is a Story." It is indeed—if it's life or death. But that was not part of the contest. As noted on Planned Parenthood's website, "Children under age eighteen must have parent or legal guardian's permission to submit their designs [for the poster contest] for us to publish them under the name." Helpfully, the website provided a parental consent form to be signed by the parents.

The various so-called pro-choice organizations, including Planned Parenthood, have often objected to parental consent laws for underage daughters planning to have an abortion. But Planned Parenthood insists that children not old enough to vote must get their parents' consent to enter a poster contest—but not to end a human life.

J.P. McFadden, I'm quite sure, would be interested to learn that, according to a recent study at the Harvard/MIT data center, the parental involvement and informed consent laws have been steadily reducing abortion rates.

However, another life force has been developed to further significantly reduce abortion—3D/4D "Four dimensional ultrasound scanning" that, as the Focus on the Family's magazine, *Citizen*, reports in the June, 2003 issue, "offers parents the opportunities to see before birth their babies moving with incredible surface detail that delineates facial and body features."

Doctor Robert Wolfson, a Colorado Springs perinatologist, says that this "creates a commitment to the pregnancy, and the individual on board, from both parents . . . It's all about the fact that you can fall in love with your child before birth."

This 3D/4D ultrasound scanning is increasingly becoming available, with the result that the choices for life are multiplying—no matter what the Supreme Court, or the Democrats on the Senate Judiciary Committee, to whom commitment to abortion rights is a necessary qualification for the federal judiciary, try to do about the moving clarity of the human lives waiting eager to join us.

A key part of J.P. McFadden's legacy is the *Human Life Review*, which is indispensable to those of us who are trying to carry on J.P.'s work.

I was honored to become a friend of John Cardinal O'Connor, and I remember him saying that of all the huge number of letters he used to receive, the one he prized most came from, he wrote, "a young woman who had simply heard me say something on television about the right to life of the unborn baby. She wrote to tell me that she had literally been on the way to an abortion. And simply because of hearing what I said on television, she had decided to let her baby live."

I expect that because of the legacy of James P. McFadden, there are a good many other lives that have been saved.

And having said that, I can imagine J.P. looking at me quizzically and saying to me, "Tell me again why you're an atheist." I would tell him what Cardinal O'Connor once told me, after the once-wholesale abortionist, Dr. Bernard Nathanson had converted to Catholicism. "I hope we won't lose *you*. We don't have many pro-life, Jewish, atheist civil libertarians."

You won't lose me, because if I were ever to falter, I would feel the spirit of J.P. McFadden and straighten right up.