VITAL SIGNS

CANADIAN PHYSICIANS FOR LIFE NEWSLETTER

Fall 2002

A proposal for a new strategy towards abortion

Editorial by Dr. Will Johnston, President

There will never come a time when it is right to kill our own young, no matter how small or early in their lives. Why are we doing it, more and more? When individuals are addicted to a drug we speak of "harm reduction". Realistically, we may not expect to eliminate all use of the drug but we try to limit the damage by warning the addict, offering counseling, offering alternatives to drug use. Perhaps it is time to see that our society as a whole has become addicted to abortion and to consider abortion as a good target for harm reduction. At a minimum, we warn – the physical risks, the emotional and relationship damage – and at a minimum we stop promoting the addiction as any kind of solution to our problems.

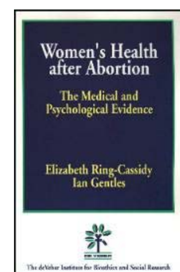
Black slavery offered the same challenges. Our society was addicted to it for reasons of convenience and self-interest, willful blindness to the wrongs being daily committed, a state of denial about the bad consequences, and the institutionalization of the social evil so that the elite had a vested interest in thwarting change. Later, the women's suffrage movement addressed social evils with some of the same characteristics.

In western society, both slavery and the political subjugation of women ended after years of appeals to conscience and rational debate and, perhaps as important, shifting economic conditions which made the attendant injustices less useful to society at large. Does this help us to understand our current struggle?

"First, do no harm." We need to return to first principles in giving "reproductive health care". In the case of abortion, this means seeing it as bad public policy. A good public policy does more good than harm. In contrast, the promotion of abortion causes direct harm and feeds the unreflective trend to sexual promiscuity, which leads to disease and infertility and prevents the formation of stable families. The availability of abortion provides women with only one service – the severing of relationships: to children, to fathers, and to others. Whether it is a good idea for society to promote and provide this service, ever more heavily, should be the question.

It seems apparent that the issue of abortion has produced unusual distortions of democracy. Significant Canadian majorities favor defunding it, yet it remains publicly funded. Significant majorities favor some restriction of it yet it remains unrestricted. Significant majorities disapprove of it, yet its availability continues to be actively promoted by government agencies and their proxies. Significant majorities of doctors want nothing to do with it, and would never "do one", yet it remains promoted by medical organizations.

"First, do no harm". It seems to me that to at least *cease approving* of abortion and to *stop officially commending* it is an attitude change we can reasonably ask of our leaders, and is also an achievable political goal. This first step in a new direction will require several preparatory efforts, which I will propose in our next Vital Signs.



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S I G N S

Canadian Physicians for Life Newsletter

VITAL SIGNS is published by Canadian Physicians for Life, a registered charitable organization. Canadian Physicians for Life holds that reverence for every human life lies at the root of all medical tradition. Through the ages, this tradition has been expressed in the Oath of Hippocrates. It was rephrased in modern times in the Declaration of Geneva, which says in part, “I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity." We affirm this declaration.

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Choice means making up your own mind

by Nigel Hannaford

When a Toronto pro-life counsellor got maced in a hospital waiting room, he realized what some abortion advocates mean by the word choice.

Right beside the abortion clinic at 302 Gerrard St. East, is Aid to Women, a Christian-based pregnancy crisis centre where Robert Hinchey works.

On Aug. 29, a five-months pregnant, 18-year-old girl from Grenada visited the centre. She was not a legal resident of Canada. Her story was that her mother had sent her to Canada to remove her from an abusive home situation. Having become pregnant, she was pressured by her boyfriend to have an abortion. With no place to live, she was accepted by the YWCA STOP 86 shelter and counselled to get an abortion at the Gerrard Street clinic.

Joanne Dieleman, Executive Director of Aid to Women, says the young woman had already had work done at the centre in preparation for the procedure, but then told her she did not want the abortion.

"We therefore agreed on a plan," says Dieleman. "We arranged to have the preparatory work undone: Thereafter, we had accommodation arranged where she would be cared for. We also offered to pay her fare home to Grenada."

The girl's visit to the pro-life centre had been observed, however. She received several phone calls at the centre, but declined to take them. Dieleman says that the return number was that of the STOP 86 shelter.

When the girl left the pro-life centre with a counsellor, the two were approached by a woman associated with the abortion clinic, but kept on to a waiting car driven by Hinchey. The three then drove to the St. Michael's Family Practice Clinic on Queen Street to have the laminary tent removed.

While they waited, members of the Toronto City Police arrived and interviewed the girl. Satisfied that she was there of her own free will, they left and the girl resumed her place beside Hinchey in the waiting room.

What follows beggars belief. According to Hinchey, two women approached and seized the girl by the arms, dragging her toward the elevator. Hinchey called security; when the security officer was ignored, he too tried to intervene.

That was when one of the women sprayed his eyes with what a St. Michael's spokesman identified as mace. Staff and other patients had been affected; when Hinchey could open his eyes 10 minutes later, it was to see police, ambulance and firemen clearing the waiting room. The girl was gone.

Toronto police confirmed a few days later that charges of assault with a weapon had been laid at the scene against a woman, who was then released; she is to appear in court Oct. 28.

Within an hour, police visited Dieleman to tell her the girl had changed her mind and was having the abortion.

"Outside in the street, there were four police cruisers and a sheriff. Somebody really wanted to make sure we didn't talk to her again," says Dieleman.

A number of questions arise, such as why a person charged with using mace against another person would simply be charged and released, but four cars were deployed to secure the girl's uninterrupted access to the abortion clinic. Also, why only one of the two women who invaded the hospital waiting room was charged and why no charges relating to the seizure of the girl were lodged. The police aren't saying much.

Beyond that, however, is whether this girl was well served by such ideologically driven militancy.

She could at this moment be awaiting the birth of her child in safe circumstances, with the prospect of returning to Grenada or more likely, having her Canadian residency regularized. Instead, she remains a vulnerable, traumatized alien with no prospects. It is hard to imagine how those who seemed determined to ensure she had the abortion could call that a better outcome.

Nobody from STOP 86 wished to comment. Despite their reticence, there is this to be said for them: People do what is right in their own sight, not what is wrong.

To somebody who doesn't see abortion as inherently evil, this girl was a prime candidate, young, in a difficult spot, and likely to be a charge on the state. Somebody thought they were giving her the best advice possible.

I also personally doubt that STOP 86's official policy is to invade waiting rooms with mace, or encourage others to do so, though it would have served them better to say so. Yet, it is outrageous that a person would do so and seize a woman who had decided not to proceed with an abortion. It goes beyond advice and persuasion. It is the antithesis of choice.

Calgary Herald - Sept. 21, 2002
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Teen Sex: Reality Check

Edmonton Obstetrician/Gynaecologist Dr. Stephen Genuis and his wife, Shelagh, have produced a new book entitled *Teen Sex: Reality Check* and a video called *Teen Sex: Reality Strikes Back*. They bring forward some of the most recent disturbing information about sexual behaviour and consequences. Dr. Genuis believes that "the tragedy of abortion that is so prevalent throughout the world can most effectively be addressed in teenagers by preventing unintended pregnancy."

According to Dr. Genuis, these resources are designed to help parents protect their children; to help educators understand the need for a consistent and healthy message regarding sexual behaviour; to encourage the health profession to adopt a correct stance regarding sexual involvement; and to enlighten public policy leaders to support programs that protect and save the health of young people.

"With the recent estimation that most young men in prison are offspring of teen moms, with millions of teens world-wide infected each and every year with an STD, with the very recent recognition that some childhood cancers and mental illness are likely resulting from STDs in the mother, with the admission that HIV/AIDS is now the worst plague in the history of mankind, and with the abysmal failure of technological devices to deal with these tragedies, it is evident that this area needs to be urgently addressed. We feel that the information is very important and believe that the scientific evidence leads to a conclusion that is irrefutable."

"Although I do not use Christian lingo, nor focus on spiritual truth, as a physician it is my sincere belief that scientific truth needs to be communicated to society as well as moral and spiritual truth. The Creator of spirituality is also the Creator of science and it is my belief and my experience that Faith & Science should go hand in hand. As Albert Einstein stated 'Science without religion is lame, religion without science is blind.' It is my view that when we learn the laws of science, we are peeking into the mind of God; when we observe His rules and regulations regarding medical fact and scientific reality, we are abiding by His order of creation."

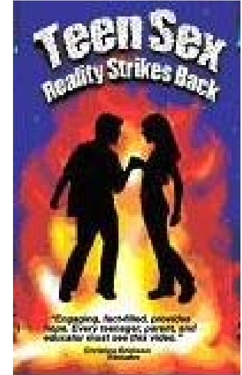
"With the increasing recommendation that physicians directly encourage parents to address sexuality with their teens and preteens, we hope that the book will be used by doctors to give to their patients to educate them and that the video will be given to patients to show their teens. The book is directly designed for parents and educators and has the most recent medical research and information from throughout the world. We try to tell a lot of stories and present research in an easy to understand fashion."

The video, on the other hand, is specifically designed for teens. Some of the scenes from the video include

- ❖ Meeting Internet Contacts
- ❖ Sex and the Media
- ❖ Sex, Drugs, and Alcohol
- ❖ Myth of the Invincible Teen
- ❖ Safe Sex – Fact or Fallacy?
- ❖ The STD Chain
- ❖ Short-Term Game, Long-Term Pain
- ❖ Lifestyle Options
- ❖ Living with HIV – a Young Woman's Story
- ❖ Making Healthy Choices

The video uses dramatic scenes acted by teens to present lifestyle options and to encourage viewers to make health enhancing decisions.

Dr. Genuis is passionate about reducing suffering through the promotion of health. Shelagh Genuis received the 2002 Medical Library Association Scholarship for academic excellence and potential achievement in health sciences information studies. Together they have produced several excellent resources including, *Teen Sex: Challenge and Decision*, recipient of the Society of Obstetrics and Gynaecology of Canada's 1995 *Best Video Award*.



Order these resources from Winfield House Publishing
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Dr. Genuis' award winning 1995 video, *Teen Sex: Challenge and Decision* (French version, *Le Sexe chez les Adolescents: Défi et Décision*) is also available

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Mandatory abortion training

Kathryn Jean Lopez, Associate Editor, National Review

"Bloomberg's Gift"
July 1, 2002

Used with permission.

New York City mayor Mike Bloomberg "will be a pro-choice hero," the *Village Voice* promised shortly after his inauguration earlier this year. And hero he is – not just to the abortion advocates in New York, but to the whole industry. Bloomberg may have just saved abortion in America…

Mayor Bloomberg's gift to New York City is a guarantee that the numbers of abortion practitioners will increase. Starting July 1, doctors trained in New York City public hospitals – the nation's largest public hospital system (it trains one-seventh of the nation's doctors) – will be required to learn the art of abortion. It was previously an elective.

About 2,000 doctors currently perform abortions in the U.S. With more than half of them over 50, mandatory abortion training has long been on the wish list of the National Abortion Rights Action League (to which Bloomberg has been a financial contributor) and now it is law. Their hope is that other cities will quickly follow suit.

A *Washington Post* writer, upset about RU-486 not catching on with women, recently editorialized on Bloomberg's abortion push:

> [N]o one should assume that the provider shortage has gone away. If anything, RU-486, and the response to it, point out the need for doctors comfortable with abortion procedure. Proponents should keep looking for ways to produce them: A good model is New York Mayor Michael Bloomberg's move to require abortion training as part of ob-gyn residencies in the city's public hospitals. More than a new pill, this initiative gets at the root of the shortage: a generation of doctors who have not seen the effects of illegal abortion and who often find in medical school that abortion training is unavailable, nonmandatory or inconvenient. Under the Bloomberg plan there will be a conscience clause for residents who don't want to do abortion, as there should be. But this sort of effort, if brought to bear elsewhere, might help produce a generation of doctors qualified to provide abortion, surgical and medical, ably and safely.

While proposals like the Human Life Amendment and a ban on partial-birth abortion have proved near-impossible to enact in law, the lack of interest in abortion on the part of doctors – and the aging of those practitioners who are most passionate about it – has increasingly been considered a sign of hope by those opposed to abortion. The pro-abortion groups, meanwhile, are in a tizzy. But if Bloomberg's move starts a trend, it could revive the practice of abortion in America.

Or not. The new training mandate allows for a religious/conscience exemption for those with moral qualms about abortion. And for the rest, a taste of abortion – as contrasted with the joys of delivering fully live children (who, not too long before, could have been legally killed) – could well turn new doctors off to the deadly procedure, breaking the hearts of abortion activists. In a 1998 piece in the *New York Times Magazine* ruing the decline in doctors below the age of retirement who are willing to perform abortions, the reporter noted with dismay the attitude of OB-GYN residents who, though perfectly free to do them, still don't want to touch abortion. "Some of them," Jack Hitt wrote, "have the kind of revulsion you expect to find among abortion protesters."

> "If you do 12 in a row, it can make you feel bad," the chief resident said. "No matter how pro-choice you are, it makes you feel low." Another resident said, "I guess I never realized I would find it as unpleasant as I do. I really don't enjoy it [at] all. It's not a rewarding thing to do."

In other words, NARAL, don't break open the champagne just yet.

Mrs Pretty and Ms B: Law, death, and medical ethics

Concurrent cases which came before the English High Court regarding the right to die are discussed in the August issue of the *Journal of Medical Ethics.* Paralysed by motor neurone disease and unable to take her own life, Mrs. Pretty wanted her husband to be allowed to help her to die. The English courts refused Mrs. Pretty's request to grant her husband legal immunity so she turned to the European Court of Human Rights, arguing that the English courts' refusal had violated the European Convention on Human Rights.

The European court, however, judged that there had been no violation. The right to life (article 2 of the convention) could not be construed as conferring a "right to die", and consequently the state could not be required to "sanction actions intended to terminate life."

Ms B, a woman with tetraplegia for a year, sought a ruling that doctors be allowed to turn off her ventilator. The English High Court decided that she was competent to refuse treatment, and a month later, her ventilator was switched off and Ms B died in her sleep – on the same day that the European Court of Human Rights announced its decision in the case of Mrs Pretty.

As stated by Dr. John Keown, Cambridge Faculty of Law, "Few, if any, ethicists or lawyers would question a patient's right to refuse treatment because it is either futile or too burdensome." However, in the case of Ms. B, refusal of treatment was clearly suicide, treatment was refused "precisely with the intention (purpose) of putting an end to life." Dr. Keown questions, "…if the courts recognise a right to commit suicide by refusing treatment and allow or even require doctors intentionally to assist their patients to commit suicide thereby, the law's prohibition on actively assisting suicide is gravely undermined. What is the moral difference between intentionally assisting suicide by an omission and by an act?"

Dr. Keown is uneasy with the court ruling of an absolute right of a competent patient to refuse treatment, "notwithstanding that the reasons for making the choice are rational, irrational, unknown, or even non-existent."

As are disability rights activists Diane Coleman and Stephen Drake of *Not Dead Yet.* In a detailed critique of Ms. B's testimony and the Court ruling, Coleman and Drake argue that the ⇒

Abortion's health effects reported

Women who have abortions are at significantly higher risk of death than women who give birth, according to a study published August 2002 in *Southern Medical Journal*[1]. "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women" reports on research which linked California Medicaid records for 173,279 women who had an induced abortion or a delivery in 1989 to death certificates for 1989 to 1997.

Compared with women who delivered, those who aborted had a significantly higher age-adjusted risk of death from all causes (1.62), from suicide (2.54), and from accidents (1.82), as well as a higher relative risk of death from natural causes (1.44).

This is the second major record-based study to link abortion to elevated mortality rates. In 1997, a study of women in Finland revealed that in the first year following an abortion, aborting women were 252 percent more likely to die compared to women who delivered and 76 percent more likely to die compared to women who had not been pregnant. According to Dr. David Reardon, one of the California study's authors, their objective was to examine the association using an American population over a longer period. The study concludes that higher death rates associated with abortion persist over time and across socio-economic boundaries. This may be explained by self-destructive tendencies, depression, and other unhealthy behaviour aggravated by the abortion experience.

The California data was also used in a study published in the July issue of *The American Journal of Orthopsychiatry*[2] which reveals that aborting women seek more subsequent mental health care. By examining 173,279 Medi-Cal records, the research team compared the rate of psychiatric outpatient treatment for women who had abortions versus those who carried to term. To control for differences in prior psychological health, they excluded all women who had any psychiatric care for a year prior to their pregnancy outcome.

Women were 63 percent more likely to receive mental care within 90 days of an abortion compared to delivery. In addition, significantly higher rates of subsequent mental health treatment persisted over the entire four years of data examined. Abortion was most strongly associated with subsequent treatment for neurotic depression, bipolar disorder, adjustment reactions, and schizophrenic disorders.

Dr. Priscilla Coleman, the study's lead author, said that the study design was an improvement over previous studies because it relied on medical records rather than on surveys of women contacted at an abortion clinic.

"Most studies of mental health status after an abortion rely on small groups of women–usually less than 300–and face high drop out rates of 50 percent or more," said Coleman, a professor at Bowling Green State University in Ohio. "By looking at medical claims for a large group of women, we were able to capture a more accurate picture of the differences between abortion and childbirth."

Another of the study's authors, Dr. David Reardon, said, "Our results are likely to underestimate the true difference in psychological treatments because the information on obstetric histories was incomplete. Since many of the women classified as 'childbirth only' actually had prior abortions which we did not know about, this would most likely dilute our findings."

A third study co-authored by Reardon, published last January in *the British Medical Journal*[3], reveals that subsequent long-term clinical depression is more common among those women who have had abortions.

Dr. Reardon hopes the results of recent studies will rekindle the effort to make the investigation of abortion's health effects a priority.

"The government has ignored this problem for decades, largely at the behest of population control groups which are more concerned about protecting abortion than protecting women," he said. "I believe women deserve better. They deserve to know the true relative risk associated with abortion.

[1] Reardon, DC, Ney, PG, Scheuren, F, Cougle, JR, Coleman, PK, Strahan, TS. Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women. *Southern Medical Journal,* Vol 95. No 8. August 2002, 834.

[2] Coleman PK, Reardon DC, Rue VM, Cougle JR. State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over five years. *American Journal of Orthopsychiatry*, 2002, Vol. 72, No. 1, 141–152.

[3] Reardon, DC, Cougle JR. Depression and unintended pregnancy in the national longitudinal survey of youth: a cohort study. *BMJ* 2002; 324: 151-152

Mrs Pretty and Ms. B…

continued from page 4

outcome may have been influenced by unquestioned assumptions about the quality of life of people with severe physical disabilities and also by inadequate provision of resources. They are concerned about lack of informed consent and denial of treatment alternatives, and the cavalier manner in which these factors were dismissed by the Court.

Controversial Princeton ethicist, Dr. Peter Singer, argues that both Mrs. Pretty's wishes as much as Ms B's, ought to have been respected. In his view, the "supposedly harmful" consequences of legalising assisted suicide are no greater than those of respecting the right to withdrawal of treatment. Also in the U.S. and Canada, we have built "legal doctrines based on two separate rules of law" (the competent adult's right to refuse treatment, and the prohibition of assisting suicide) "and thereby we have reached a situation that makes no ethical sense at all."

Dr. K. M. Boyd, *Journal* deputy editor and Professor of Geriatric Medicine, brings up the concern expressed over a century ago by Sidgwick that "traditional moral rules are easier to break down than new ones are to build up, and that utilitarian improvements on traditional moral rules may depend for their success on making moral distinctions that are too fine or complex for practical purposes."

Altogether an interesting discussion. *JL, Editor*

(Reading
http://jme.bmjjournals.com/

Assisted-Suicide Doctors Sought

Kaiser Permanente NW sparked a firestorm of controversy after it sent an email to 740 physicians asking if they would be willing to act as an attending physician at an assisted-suicide. Critics accused the HMO of being more interested in offering suicide than paying for palliative care.

"Recently our ethics service had a situation where no attending MD could be found to assist an eligible member in implementing the law for three weeks, during which time this person was suffering and actively dying," the e-mail stated. Dr. Gregory Hamilton, president of Physicians for Compassionate Care, questions why the communication did not explain why the patient's suffering was not adequately treated and relieved for three weeks or what Kaiser Permanente proposes to do to improve its pain treatment and palliative care.

According to Kaiser's e-mail, participation in physician-assisted suicide is voluntary, and when the patient's primary care or specialist physician is unwilling to participate, it is up to the chief of the physician's primary or specialty care service to find someone who will. Dr. Hamilton, a Portland psychiatrist, said he was glad the HMO had such a difficult time finding a doctor willing to participate in an assisted suicide. "They know it's still unethical, according to the American Medical Association and virtually all other medical associations," he said. "We can treat pain and depression; we don't need to overdose people."

This e-mail, according to Dr. Hamilton, represents the first step down the slippery slope of killing patients to save money. "This is what we've been worried about. Assisted suicide would be administered through HMOs and by organizations with a financial stake in providing the cheapest care possible," he said. "A lot of people thought it would be between them and their trusted doctor, but that's not what's happening. If someone wants assisted suicide, they go to an assisted-suicide doctor – not their regular doctor."

http://www.pccef.org/

John Paul's 'gospel of life'

Fr. Richard John Neuhaus: *Invited commentary to coincide with World Youth Day*

National Post – July 24, 2002

"The human project" may strike many as an odd phrase. It is, however, at the heart of the thought and ministry of John Paul II. His entire message to the Church and the world is aptly described as "prophetic humanism." It is prophetic because it challenges culturally dominant views of the human person and the human future. It is humanistic because it insists that God Himself, by becoming a human being in Jesus Christ, is irreversibly committed to the flourishing of the human project.

The theme of human dignity is everywhere present in the numerous teaching documents of this pontificate. John Paul's prophetic humanism exhorted the Polish people to stand up and "live in the truth," thus precipitating the beginning of the end of Soviet Communism. The same prophetic humanism warns the affluent West against a consumerism that reduces the human person to a unit of consumption, while, at the same time, it exhorts us to open the circle of economic productivity and exchange to the poor peoples of the world. It is also prophetic humanism that compels John Paul to reach out to other world religions in order to heal the wounds of the past and to build together a future worthy of the divinely bestowed dignity of the human person.

In October 1978, in his first homily as Pope, John Paul repeatedly declared, "Be not afraid." That phrase -- echoing the words of the risen Christ to his despairing disciples -- has been the constant refrain of his pontificate. In a world in which there is so much to fear, some have been led to say that John Paul is an optimist. He is not an optimist but a man of irrepressible hope. Optimism is a disposition to see what we want to see and not see what we don't want to see. Optimism is a matter of optics, a form of selective blindness. Hope looks at reality unblinkingly, seeing all that is fearful but insisting that we finally have not a right and have not a reason to despair.

Among the many threats to the human future, says John Paul, is "the culture of death." He proposes the alternative of "the gospel of life," which in Latin is the title of his 1995 *encyclical Evangelium Vitae.* The culture of death takes many forms. The killing of unborn children is a direct and brutal assault against humanity created "in the image and likeness of God." Similarly, euthanasia, assisted suicide, and eugenic proposals for eliminating those who are deemed to be "unfit" all reduce the human person to an expendable "thing," making the weak subject to the decisions of the powerful. John Paul calls upon the friends of the human project to bear effective public witness to the moral truth that every human being is an end in himself and never merely a means to the ends of others.

Today we are confronted by an array of new threats to the human project. Turning the human person into a product, genetic engineering and related biotechnologies are leading us toward the dehumanized dystopia foreseen in Aldous Huxley's prescient novel, *Brave New World*. Some claim that John Paul is an alarmist in raising these cautions, but these manipulations of the human, typically defended in the name of alleviating suffering, are today being proposed and in, some cases, practised. Already now, human life is created in the laboratory, subjected to research experimentation, and then destroyed. Already now, scientists experiment with the cloning of human beings and even the creation of hybrids between the human and other species. The culture of death triumphs not only in the killing of innocent human beings, but even more ominously in the redefining of what it means to be human.

John Paul has said, "The Church imposes nothing; she only proposes." Against the encroaching culture of death, prophetic humanism proposes a better way. It is the way of respect for the irreducible dignity of the human being -- no matter how small or how young or how dependent, no matter of what sex, class, religion, or race. Each is an end to be respected, indeed reverenced, and never merely a means to the ends of others. John Paul's call to affirm the human project is hardly original with him. His is simply the most influential voice of our time bearing witness to the prophetic humanism of biblical religion.

As John Paul says, the message of *Evangelium Vitae* addresses to our time and circumstance the ancient words of Deuteronomy 30: "I call heaven and earth to witness against you this day, that I have set before you life and death, blessing and curse; therefore choose life, that you and your descendants may live."

Mifepristone: Less Obvious Adverse Effects

by Gene Rudd, M.D.

Since the Food and Drug Administration (FDA) approval of mifepristone for termination of early pregnancy, the fervor of many moral objectors has led them to focus on the drug's physical adverse effects. Although these adverse effects (e.g., cramping, vaginal bleeding, risk for surgical intervention) are valid concerns, the psychological and spiritual distress of chemical abortion and the threat to the integrity of our medical profession are greater dangers.

Some have promoted this regimen, asserting that women may choose medical abortion for reasons of privacy and autonomy. These may be the significant determinants in selecting chemical abortion rather than a single-step surgical abortion. Yet, the consequences associated with this autonomy raise concern. A woman terminating her pregnancy with mifepristone not only assumes more personal control, she assumes a higher degree of personal responsibility. Unable to cite outside forces, she is likely to feel more culpable and therefore more vulnerable to private grief and guilt. In addition, chemical abortion is an extended process simulating a miscarriage–something women who have had this experience typically recall with anguish. A multiday abortion process may further reinforce negative memories or guilt. (Although it is not detailed in this opinion, the willful ending of innocent human life is sin in the Judeo-Christian context from which I write.)

A woman with inexplicable chronic pelvic pain first made me aware of the repressed guilt many women who have had an abortion suffer. This woman had never admitted having an abortion to anyone, including her physicians. On the initial history she submitted to my office, she denied having had an abortion. However, while searching for a clue to her distress, I surprised her with a direct question about abortion. Buried grief and guilt then overflowed.

The consequent healing of these emotions led to resolution of her physical complaints. This encounter prompted me to ask subsequent patients with ambiguous physical and psychological distress about prior abortions. I learned that for many women, the experience of abortion has a lasting and deleterious impact on health. Women who have autonomy over the experience of bleeding, cramping, and passage of tissue associated with chemical abortion, are open to greater risk for psychological distress, buried more deeply.

Chemical abortions could have a lasting negative impact on the medical profession as well. Although approval of mifepristone is not likely to result in more abortions, many more physicians are expected to become involved in the chemical abortion process. With mounting professional problems, the medical community does not need reason to further tarnish its profession.

When Hippocrates began writing on medical ethics, contemporary physicians often took physical, sexual, and financial advantage of patients. The Pythagoreans later developed Hippocrates' ethics into a code of conduct. Few doctors initially subscribed to these ethics, but patients motivated to find physicians that would "do no harm" voted with their feet. Once defined, the ethical code and the public's demand for it drove the medical community to accept this standard (i.e., always protecting life) that revolutionized and defined Western health care for centuries.

History reveals the dangers of breaching this commitment. In the middle of the 20th century, a medical community's decision that some lives were not worthy to be lived ushered in a period of gross human rights abuse. In speaking of the German medical community, Alexander III wrote:

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

When the medical community chooses to participate in killing on any level, there is a clear risk of undermining its public trust and, worse, opening the door for expanded unconscionable behavior. The greatest concern in the FDA approval of mifepristone is that we have taken one further step down the road that begins where society deems any life unworthy to be lived. Once such categories are allowed, they need only be expanded. Current desires for individual autonomy or control will continue to fuel the expansion. As regrettable as the individual psychological scars of abortion are, they pale in significance to the dangers we face when our culture chooses to selectively end human life. Regardless of society's choice, for the sake of our integrity, the medical community should not facilitate this act.

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FDA Petitioned to Shelve RU-486

On August 20 the Christian Medical Association, American Association of Pro Life Obstetricians and Gynecologists and Concerned Women for America filed documents* with the United States Food and Drug Administration (FDA) calling on the agency to shelve the chemical abortifacient RU-486 pending a thorough review of its own approval process and the subsequent deaths and complications attributed to the abortion drug. Wide national media coverage followed.

In a Washington, DC press conference and other media interviews, CMA spokesperson Dr. David Hager raised questions on the effect on adolescent users, ectopic pregnancy, and informed consent.

"The FDA is not enforcing the evaluation of violations of the guidelines issued concerning the proper use of RU-486," he said. "[We] call for the immediate suspension of the sale of Mifeprex and for extensive and careful investigation of the potential life-threatening effects of its component agents."

*The 90-page "citizens petition" based on 22 months of research as well as a summary can be accessed at www.cmdahome.org

The Ends Don't Justify the Genes

by John F. Kilner

Is there anything wrong with causing someone to be paralyzed, or blind, or deaf? If so, then sit up and take notice.

On March 31 the Sunday magazine of the *Washington Post* featured a cover story on a couple who have intentionally produced a child who cannot hear. The couple themselves are deaf and lesbian, so when a sperm bank would not provide them with a deaf donor, they found one themselves. "We wanted to increase our chances of having a baby who is deaf," one of them explained. And they succeeded–their baby is "quite deaf." They claim their attempt to maximize their happiness was legitimate. But was it?

As we learn more about the human genetic code and develop tools to change it, this situation raises a huge question that society needs to answer soon: Is it ethical for parents to force their child to have genetic traits that will be harmful to the child but beneficial to the parents? Most people would have no problem with parents correcting a genetic problem in a baby so that the baby will not have to suffer from some disability. But what if the parents want to cause the baby to have that disability?

Two responses. First, all people including parents should be free to pursue their desires–but not in ways that prevent others from pursuing theirs. Being able to make choices is good–but not if our choices take away the choices of others. My freedom is important; but I am not free to do something that will undermine yours.

We expect an even higher standard from parents: they should be seeking the greatest well-being for their child, even at some cost to themselves. But at a minimum, parents ought not to disadvantage their child so that they, the parents, can benefit. Even the staff member at the National Association of the Deaf quoted in the Post article honestly acknowledges the core problem with being deaf: "You don't have as many choices." The couple in this situation have intentionally limited the choices of their child by imposing the disability of deafness, and that is unethical.

And the issue here is not about being supportive of people who are deaf or otherwise disabled. There are several deaf people in my extended family and my daughter heads the Sign Language group at her high school. I enthusiastically affirm the dignity and rights of people who are deaf. Deaf people, however, are not in danger of losing their rights in this case. This is not a "deaf rights" but a "human rights" case.

The basic issue here is whether or not there are ethical limits to what parents can impose on a child. Before genetics became a factor, the importance of limits was clear. We have not allowed parents to force young children to do hard manual labor ten hours a day so that the parents can have a more affluent lifestyle. If we now say that parents can cause their children to be without hearing, then we are saying that parents' preferences are all that matters. They can cause whatever harm to their child they wish, as long as they get enough benefit from doing so. Now is the time to draw the line. Parents (or anyone else) must not be allowed to impose, genetically or otherwise, a harmful characteristic on their child.

Second, we can more clearly see the harm of genetically limiting our children when we consider how we would view the same harm without the genetics involved. Genetic and reproductive technologies and techniques, such as the donor insemination used in this case, are simply tools. We use tools to accomplish things. Whether a use of a tool is ethical depends in part on what we are trying to accomplish with it. If something is wrong, it doesn't matter what tools we use to accomplish it–it is still wrong.

Preventing a child from hearing harms the child; it limits and disadvantages the child. Wouldn't we condemn parents who took some tool and intentionally destroyed their child's ability to hear? If they do the same thing using genetic tools, as in effect this deaf couple did, our opposition should be equally strong. To accept this genetic limiting of a child's abilities is not only to justify even more harmful genetic limitations. It also justifies using non-genetic means to limit a child – for example, destroying the hearing of a child who can hear.

In the Post article, the couple try to defend their actions in two primary ways. First, they argue that their lives as deaf people are fine, and that their child's life will also be fine. Even if this were to be true, it misses the point. Human beings are amazingly resilient, and they can adjust to, and make the most of, even the worst circumstances. But that does not mean that the circumstances are good or are to be sought or caused if possible. People who are brain damaged or paralyzed can still have a good life–but that fact does not mean that we should accept or encourage brain damaging or paralyzing people. Nor should we accept causing deafness.

Second, the couple maintain that if it is okay for some parents to try to have a black child–because they themselves are black–then deaf people should be welcome to have a deaf child. A problem with this comparison is that blackness itself does not necessarily impose major limitations on people. If society limits people because of their skin color, such limits represent prejudice and are unjustified; they should and can be removed. The limits of deafness, however, are not completely the product of human prejudice and are not all removable.

This comparison, though, raises a larger issue. How ethical is it to impose characteristics on people that are not necessarily harmful, but which they may not want? Does everyone want to be a man? Of course not. Does everyone want to be white? Resoundingly no. So is it ethical for parents intentionally to force their child to be something that he or she may not want to be?

The situation of the deaf couple and child underscores the more serious need to keep parents from making genetic choices that harm their child. But it also prompts us to consider the different wrong we do by intentionally forcing a child to have a characteristic that the child may not want.

In the end, perhaps only genetic interventions all people would want can ethically be imposed on children. Included would be those interventions that prevent fatal diseases–but there are other categories that meet this criterion as well. Identifying them is a task in which all should participate if possible, for its outcome will profoundly affect us all.

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