



VITAL SIGNS

CANADIAN PHYSICIANS FOR LIFE NEWSLETTER

Fall 2003

Backlash: Hollywood, History—and the Truth

by Charles Colson - 06/06/2003

In the 1942 tearjerker *Now Voyager* suave actor Paul Henreid says to Bette Davis: "Shall we just have a cigarette on it?" As the two gaze deeply into one another's eyes, Henreid puts two cigarettes into his mouth, lights them, and hands one to Davis.

It was considered the ultimate in sophisticated romance.

Flash forward fifty-seven years. In the hit comedy *My Best Friend's Wedding* Julia Roberts sits on the floor outside a hotel room, smoking an illicit cigarette. Her friend yanks open the door and snatches the cigarette from her fingers. "I want you to quit this [stuff] before it kills you," he snarls.

It's the ultimate in social condemnation—and a complete reversal of the cinematic attitudes of yesteryear.

What happened between 1942 and 1997 to generate such a change? The answer sheds a spotlight on how we may one day win the abortion debate.

As Frederica Mathewes-Green writes in a collection of essays called *Thirty Years after Roe v. Wade*, our grandparents embraced values that we now recognize as damaging, like cigarette smoking and heavy drinking. Those attitudes, says Mathewes-Green, were celebrated in movies in much the same way reckless sexual behavior is today. For instance, in the hugely popular *Thin Man* films, the heavy drinking of both Myrna Loy and William Powell was treated as comic relief. Anyone who objected to this view was dismissed as a moralizing busybody.

But then, something happened on the way from the *bijou* to the multiplex. Americans began losing friends to lung cancer and emphysema—friends who smoked. And drunk drivers killed thousands of people. As a result, cigarettes—which kill 400,000

Americans a year—are no longer considered glamorous. Drinking to excess—which kills 100,000 more—is no longer considered funny. And for the most part, Hollywood has stopped suggesting that they are.

It's important to understand, Mathewes-Green points out, that it wasn't all those warning labels on cigarette packages that got people to quit smoking. And it wasn't the Temperance Union that convinced people to stop getting drunk. It was truth itself and social pressure.

And that's where the abortion debate comes in. Modern films portray sexual romps as great fun—the height of hipness. Those who object are dismissed as moralizing busybodies. But just as media messages about drinking and smoking were gradually replaced with healthier messages, we will one day see changes in how Hollywood portrays sexuality, predicts Mathewes-Green. This will happen as more and more people are harmed by promiscuous behavior, watch friends die of AIDS, and see sisters, daughters, and girlfriends harmed or even killed by so-called "safe, legal abortions."

So, yes indeed, we should keep talking about the horrors of abortion, its impact on future pregnancies, and its link to depression and breast cancer. We should do so knowing we will be mocked and maligned. But we should also have hope, for the day will surely come when abortion won't be portrayed as a noble decision by brave women who are harassed by right wing, religious crazies.

Eventually, the truth will out—and we'll see it even when we go to the movies.

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VITAL SIGNS

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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SILENT NO MORE

November 6-8, Edmonton, AB

Detailed information: www.life2003.ca

Canadian National Pro-Life Conference

Sponsored by Alberta Pro-Life in conjunction with LifeCanada, Campaign Life Coalition, Euthanasia Prevention Coalition

Keynote Speaker: Dr. David Reardon, author of numerous papers (see page 3) and several books including *Aborted Women: Silent No More*
President, Elliot Institute - www.afterabortion.org

Also: Janet Epp Buckingham, Richard Doerflinger, Scott Klusendorf, Alex Schadenberg

2003 Medical Students Forum

In conjunction with the national pro-life conference in Edmonton, Canadian Physicians for Life is hosting a "pro-life medical students forum" to educate medical students regarding the life issues, initiate association between students and MD's who value the sanctity of human life, and discuss and plan how we can impact our culture as individuals and as CPL affiliates.

Canadian Physicians for Life members are invited to take part in this initiative by attending the conference and contributing to costs of sponsoring medical students from across Canada. For more information, please contact our office.

Executive director search

Canadian Physicians for Life is interested in receiving applications for a proposed part-time position of Executive Director. The ideal candidate would be an articulate individual with

- experience in medicine (physician preferred)
- experience in public and media relations,
- excellent English written and verbal communication skills; French an asset,
- ability to be flexible, self-motivated, assertive, and able to work with minimal direction,
- strong organizational, administration and time management skills,
- a home office to work from, with email

Proposals of interest can be forwarded, in confidence, to:
Dr. Will Johnston, President, Canadian Physicians for Life
c/o 10150 Gillanders Road, Chilliwack, BC V2P 6H4

Correspondence

*Variations of the following requests are frequently received by our office.
If you are willing to lend your name, please let us know!*

I know this is a long shot, but I am looking for a new G.P. I would prefer a pro-life one. Is it possible for you to identify one in my area who might be taking new patients? I was "interviewed" by a physician yesterday, who was very short with me when I asked him about his position with respect to abortion. Although there are few options in this Region, fortunately I am in no particular distress at the moment and so I am taking my time about trying to find someone... IR, Ontario

I am a volunteer with Birthright. We need to update our list of physicians that we can refer the women who come to us to, but need to be confident that the doctors are also upholding our principles... MM, Alberta

Psychiatric admissions of low income women following abortion and childbirth

A study published in the May 13 issue of the Canadian Medical Association Journal by David C. Reardon and colleagues compared psychiatric admission rates of women in time periods from 90 days to 4 years after either abortion or childbirth using California Medicaid records of 56 741 women aged 13 to 49 years.

Overall, women who had had an abortion had a significantly higher relative risk of psychiatric admission compared with women who had delivered for every time period examined.

According to a July editorial in *CMAJ*,

In light of the passion surrounding the subject of abortion we subjected this paper to especially cautious review and revision. We also recognized that research in this field is difficult to execute. Randomized trials are out of the question, and so one must rely on observational data, with all the difficulties of controlling for confounding variables. But the hypothesis that abortion (or childbirth) might have a psychological impact is not unreasonable, and to desist from posing a question because one may obtain an unwanted answer is hardly scientific. If we disqualified these researchers from presenting their data, we could never hear from authors with pro-choice views, either.

... if it is true that more explicit research into women's health issues will point the way to better care, better outcomes and more equity in access, we cannot toss out data any time we don't like their implications. Nor can we leap from a single observational study to public policy. We must allow the gradual and honest accumulation of further evidence to confirm or contradict what we think we know.

... Should we deny the publication of a study because it might be applied by one or the other side of a factionalized debate? It strikes us that the results of the study by Reardon and colleagues are neutral: they could be "used" to further the argument that abortion is undesirable; or to support arguments for better post-abortion counselling and support. We cannot second-guess such interpretations without unfairly imposing our own values on the research we choose to publish.

*Editorial - CMAJ • July 22, 2003; 169 (2)
Unwanted results: the ethics of controversial research*

CMAJ Letters

Abortion perils debated

The health sequelae of abortion are surrounded by enormous controversy, as indicated by the recent article by David Reardon and associates and Brenda Major's related commentary. My colleagues and I have also obtained evidence that women's well-being is adversely affected by abortion. We found that Canadian women who had had an abortion were significantly more likely to experience diminished well-being in the postmenopausal years than those who had not.

However, both research studies (that of Reardon and associates and our own) must be interpreted with caution. Many will rush to conclude that it is the abortion procedure itself that is associated with psychological harm resulting in mental illness or diminished well-being. These studies appear to provide evidence that women who have abortions are significantly less likely to experience health and wellness in the short- and long-term compared with women who have not undergone this procedure. Yet from the data in these studies, it is impossible to determine whether it is the procedure, the life circumstances or demographic profiles of women seeking abortion, or concomitant medical factors more commonly found in women seeking termination of pregnancy that predispose the women to poorer health outcomes. Surely those on both sides of the debate would agree that more research is needed to explore these questions.

Because the abortion debate is highly charged and clouded with ideological, political, religious and economic influences, it is sometimes difficult to objectively determine

what is factual and credible scientific information and what represents sexual and philosophical ideology. The medical and academic communities are becoming aware that "researcher neutrality" may well be an oxymoron. *CMAJ* is to be commended for allowing both sides to present their evidence. With such open debate, it is less likely that the truth will be stretched for theological or philosophical reasons or that factual evidence will be dismissed or negated for ideological and political reasons.

*Stephen Genuis
Physician
Edmonton, Alta*

In response to those who have taken issue with *CMAJ* over publication of the article by David Reardon and associates, I would like to point out that in medical ethics the concept of informed consent is of paramount importance. Regardless of one's opinions about the abortion issue, educating patients about the benefits and risks of an intervention is integral to good medicine. Thus, physicians should be willing to inform their patients of the risks associated with abortion. Aside from the usual risks associated with a surgical procedure, these include increased risks of psychiatric illness, future preterm birth, and breast cancer.

I commend *CMAJ* for refusing to allow politics to trump the scientific progress of women's health care.

*Shauna C. Hollingshead
Medical Student, University of Alberta
Canadian Physicians for Life*

Articles and letters cited are available on-line at <http://www.cmaj.ca> or request a print copy from our office.

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Is the Case for Euthanasia Dying? *Iain Murray*

A recent issue of the British Medical Journal (July 26) looked at current topics in "end of life" care. In other words, what science is currently telling us about the dying. While there were some non-related observations (including the interesting one that "fear of death is being replaced by fear of dying") the 800 pound gorilla in the living room of end of life care is euthanasia. Although one might think from the coverage of euthanasia that there is an unstoppable momentum towards its legalization, the evidence we have on the subject suggests that it is a less desirable solution than many think.

As Yvonne Mak of the University of Wales pointed out in her article, there has been very little research into what patients actually want. Most of the debate has so far focused on theoretical issues about suffering and dignity. Yet without the actual input from patients who do desire euthanasia we cannot know if the theory matches the actual desire. What Mak was able to glean from the limited qualitative research so far available was that patients' desire for death was not purely linked to their actual physical concerns, but had much more to do with their "psychosocial and existential issues."

In other words, the desire for euthanasia was not so much about pain and suffering as about their worldview and a perceived diminution of their quality of life within that worldview. As Mak put it, "disintegration [of the patient's sense of self-worth] was likely to occur earlier if patients had unresolved life events, personality problems, or poor social support had threatened their sense of wholeness." Patients whose sense of self-worth was reaffirmed by good quality end of life care tended to re-evaluate their need for euthanasia. The inference we might make from Mak's work is that doctors can help make the end of their patients' lives better by providing good psychological care, attuned to the individual patient's experiences, rather than by helping the end come quickly. As Mak says, "the desire for euthanasia must not be taken at face value."

This helps explain, perhaps, why euthanasia is rarely taken up where it is available. A study in the same issue by Dutch researchers from the Netherlands Institute for Health Services Research found that only about 3 in 10,000 patients request euthanasia. The reasons for requesting euthanasia have also changed in the last 25 years. In 1977, over half the requests for euthanasia were related to pain. Since then, as pain management has gotten better, that proportion has slipped to a quarter, with fear of deterioration and a sense of hopelessness having overtaken pain as more frequently stated reasons for the request. Although the number of requests overall has tripled since 1977, the low level of take-up of euthanasia might suggest that worries that its use might increase exponentially following legalization are misplaced. Yet its very rarity might also suggest that there is not the huge unrealized demand for it that its supporters sometimes give the impression there is.

The BMJ issue also contained an article that looked on the effect of euthanasia on surviving relatives in the Netherlands. Compared with natural death, the study found that relatives of those who had experienced euthanasia reported significantly less

traumatic grief. However, this seems to be heavily influenced by "the opportunity to say goodbye." Natural deaths only sometimes progress such that relatives are able to say goodbye to their dying loved one. This is always the case with euthanasia. Natural deaths are therefore "handicapped" by being less predictable. Once this factor was taken into account, the association between cause of death and grief symptoms was "considerably weakened." Apart from the ability to plan, natural deaths and euthanasia are about as traumatic for the relatives.

It seems, therefore, that the case for euthanasia, as frequently presented, is problematic. What research we have on the subject indicates that much of the desire for euthanasia is psychological rather than physical in its perception. Good quality end of life care could significantly reduce demand. Indeed, increased availability of euthanasia might have the reverse effect, allowing doctors to accede to demands for euthanasia when a deeper diagnosis might reveal deeper psychological issues that are driving the desire. We would do well to consider the possibility that Anna Karenina might have demanded euthanasia.

Yet even without this realization, actual demand for euthanasia is tiny where it is available, although it has increased by 200 percent in 25 years, and the supposed benefit to relatives is probably less than supposed. What society needs to ask is whether the small benefit that might accrue to some individuals is worth the risk that it might reduce the quality of end of life care to others, leading to inappropriate outcomes and mistreatment? In the U.S., we should also consider that the threat of litigation over end of life care may lead to some perverse outcomes. It is possible we may find doctors recommending euthanasia for fear that they will be sued for allowing someone to live in pain. As Mak recommends, it is vital that we get more insight into what the patients actually desire before we go down that road.

Iain Murray is a Senior Fellow at the Competitive Enterprise Institute in Washington DC

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The July 26, 2003 British Medical Journal theme issue "What is a good death?" was edited by Jocalyn Clark, BMJ, and Peter Singer of the University of Toronto.

Articles are available on-line in full text. See [//bmj.bmjournals.com/](http://bmj.bmjournals.com/)

"We wondered about excluding euthanasia from this issue, but it wouldn't go away. Even in countries that have legalised euthanasia few chose to die that way, suggesting that perhaps it's unimportant. But pressure to legalise euthanasia seems likely to grow and combine with people wanting increasing choices on how they die."

Richard Smith,
Editor, BMJ

Should a Fetus Have Rights?

Newsweek ponders “How Science is Changing the Debate”

Accompanied by two pages of 4-D ultrasound photographs of the baby from seven weeks through 35 weeks, *Newsweek*'s Debra Rosenberg writes,

“...new high-tech fetal ultrasound images allow prospective parents to see tiny fingers and toes, arms, legs and a beating heart as early as 12 weeks.” [But they] “also pack such an emotional punch that even the most hard-line abortion-rights supporters may find themselves questioning their beliefs.”

[T]he new science is also fanning long standing, divisive political feuds—over the legality and morality of ending a pregnancy . . . and ultimately the meaning of human life. . . For decades, abortion opponents have offered moral and ethical arguments about protecting the fetus. Now they're building a legal case defining the fetus—and even the embryo—as an individual entitled to basic human rights [while] abortion-rights supporters

are finding it increasingly difficult to claim credibly that a fetus just a few weeks, or even days, from delivery is not entitled to at least some protections under the law.”

The story summarizes the results of a national *Newsweek*/Princeton poll, which found that 46% of Americans believe that a human life begins at fertilization, and another 12 percent believe the human life begins when the embryo is implanted in a woman's uterus. A total of 84% believe that prosecutors should be able to bring a homicide charge on behalf of a fetus killed in the womb.

Another story, “The Tiniest Patients,” examines how treating fetuses as patients challenges their 30-year status as human beings without legal rights. The article features the compelling fetal-surgery picture of an unborn child's tiny hand reaching from its mother's womb and grasping the surgeon's finger.



The Capacity is There

A conservative bioethicist argues on behalf of the embryo

Hadley Arkes is the author of “Natural Rights and the Right to Choose” and is a fellow in Princeton University’s politics department. Excerpts from interview by Newsweek’s Debra Rosenberg.

ROSENBERG: What rights does a fetus have?

ARKES: On what grounds would one consider a child in the womb as anything less than a human being? Doesn't speak yet: neither do deaf-mutes. Doesn't have arms and legs. There are many people who are born without limbs or lose limbs in the course of their lives and they don't lose anything necessary to their standing as human beings. The fetus certainly wouldn't have a right to practice law, wouldn't have the right to use the squash courts, it wouldn't have the right to a driver's license. But certain kinds of rights that reside in human beings would not really be variable by height and weight. So the right not to be killed for a casual reason or an insubstantial reason would really not depend on the height or the weight of the baby—or its degrees of articulateness or even consciousness.

Would it be inconsistent to say that a fetus could be a crime victim but abortion is legal?

Not particularly. If the abortion were done not with the intention of destroying the child but with the intention of saving the mother, if we could say that the abortion were justified, then we wouldn't say that the fetus was the victim of a wrong.

What should be done with frozen embryos in IVF clinics?

To the extent it's practicable, we ought to arrange for the adoption of these embryos by people who are willing to gestate them. If not, then they perish. The question is whether anyone should have a veto, or whether the law itself should contain a preference for life.

So you're saying the embryo could be implanted without the natural parents' consent?

Sure. The embryo doesn't encumber any longer the body of the woman. She's not being affected by it. It doesn't encumber her

interests because she doesn't have to deal with an unwanted pregnancy. There's a tricky question here as to whether the natural parents can have property rights. The law doesn't ascribe property rights to bodies.

Can embryos be adopted?

The laws are mixed on this one. If these are human entities and they're adrift out there somewhere, they're abandoned, you can argue that we should be treating them with the same perspective we bring to other abandoned human beings.

So it's not OK to donate them to medical research?

Not any more than it would be OK for people to donate their own born children to medical research.

Is cloning OK for research or reproduction?

The matter of cloning for reproduction may actually be more arguably OK, though I have a strong aversion to it. But the case against so-called therapeutic cloning, cloning for research, could raise even greater moral questions. Would you allow parents to commit the bodies of their children [to research] without the consent of those children? Or sell the body parts of their children—not for any procedure involving the treatment of the child or the well-being of their own child, but for some speculative gain or benefit that could accrue to some other children or some other generation?

So when does life begin?

The leading textbooks on embryology say it's the union of two gametes, a male gamete or spermatozoon and a female gamete or mature ovum. You can phrase it in different ways, but on the medical side there is no dissent on this matter. What we find is that people are not arguing over the science, they're arguing over the social definition of a human being. People throw in all these other attributes—it has to be alert, and articulate. Well, many of those things aren't manifest in a newborn child. He's not snapping off witty sentences. He's not doing syllogisms. But we know that the capacity for it is there. If we know that about the child, we know that about the zygote or the embryo.

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An Unnecessary Evil

Clarke D. Forsythe

When William Wilberforce rose in Parliament on the evening of May 11, 1789 to give his maiden speech against the slave trade, he argued that the trade was both inhumane and unnecessary for the British economy. His words were part of a conscious strategy that began in 1787, when the British Abolition Committee “concluded that the general, moral case against the slave trade had been made and that the way to induce a positive readiness to end the trade was to demonstrate that it was impolitic as well as unjust and inhumane.” Consequently, the Committee “more particularly directed their attention to the plea of political necessity which is frequently urged to justify... this traffic.” As the historian Roger Anstey observed, this was the beginning of a conscious program of “advocacy which was henceforth to be frequent in the whole abolition campaign.” That program took twenty years, until Parliament abolished the slave trade throughout the Empire in 1807.

The cause for life in America has yet to reach the second stage. The argument that the unborn are human lives has been largely won. It is now time for a coherent, sustained, and concerted effort to demonstrate that abortion is “impolitic”—bad for women as well as the unborn. As was the case with the slave trade, such a program is needed to counter the notion among many Americans that abortion is a “necessary evil.” In carrying their argument to Middle America, pro-lifers must go beyond preaching to the anti-abortion choir: they need to make their case in ways that appeal to those who are currently undecided or conflicted on the issue. As Chesterton put it, “We must either not argue with a man at all, or we must argue on his grounds, and not ours.”

A 1991 Gallup Poll on “Abortion and Moral Beliefs” found that 77 percent of Americans believe that abortion is at least the taking of human life, if not murder itself. More specifically, 49 percent considered abortion “murder,” while an additional 28 percent thought of it as “the taking of human life.” Several more recent polls confirm that virtually half of all Americans consider abortion to be “murder.” As sociologists James Davison Hunter and Carl Bowman rightly conclude, “The majority of Americans morally disapprove of the majority of abortions currently performed.”

Yet while many Americans believe abortion is wrong, they also believe it should remain legal. The *Chicago Tribune* aptly summarized the situation in a September 1996 editorial: “Most Americans are uncomfortable with all-or-nothing policies on abortion. They generally shy away from proposals

to ban it in virtually all circumstances, but neither are they inclined to make it available on demand no matter what the circumstances. They regard it, at best, as a necessary evil.”

If Middle America—as Hunter calls the 60 percent in the ideological middle—sees abortion as an evil, why is it thought to be “necessary”? While the 1991 Gallup Poll did not probe this question specifically, it did make clear that it is *not* because Middle America sees abortion as necessary to secure equal opportunity for women. For example, less than 30 percent believe abortion is acceptable in the first three months of pregnancy if the pregnancy would require a teenager to drop out of school (and the number drops below 20 percent if the abortion takes place after three months). Likewise, less than 20 percent support abortion in the first three months of pregnancy if the pregnancy would interrupt a woman’s career (and that support drops to 10 percent after three months).

Instead, many Americans may see abortion as “necessary” to preserve women’s health—and this despite the fact that such a

It is now time for a concerted effort to demonstrate that abortion is “impolitic”— bad for women as well as the unborn.

view is based on easily refuted misperceptions. In fact, during our unprecedented experiment in abortion-on-demand over the past three decades, the health of untold numbers of women has actually been damaged. This is thoroughly documented in a recent book by Elizabeth Ring-Cassidy and Ian Gentles, *Women’s Health after Abortion: The Medical and Psychological Evidence* ...

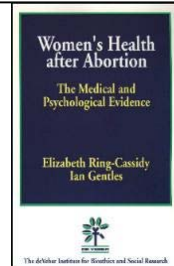
Behind the slogans about women’s freedom is the disaster of disordered lives. The social experiment with abortion has aggravated the very problems—like illegitimacy, child abuse, and domestic abuse—that it promised to solve. It has isolated women in their pregnancies and made them more vulnerable to violent abuse from uncommitted men. Can anyone say that legalized abortion has fulfilled its promise to reduce child abuse, or to reduce illegitimacy, or to reduce poverty?

Such misperceptions explain the seemingly contradictory polls showing that a majority of Americans believe that abortion should remain legal despite believing that it

Women’s Health after Abortion The Medical and Psychological Evidence

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is murder. While the most committed pro-life Americans see legality and morality to be inextricably intertwined and thus view the polling data as contradictory, Middle America understands “legal” and “illegal” not in moral but in practical terms: Is criminalizing the procedure a realistic solution? It is commonly believed that prohibitions on abortion would not reduce abortion but would only push thousands of women into “the back alley” where many would be killed or injured, despite the evidence to the contrary. In 1957, for example, only 260 deaths could be traced to abortion. By 1972, the year before *Roe v. Wade*, only thirty-nine women died from illegal abortions, while twenty-seven died from legal ones. So much for the back alley.

While Middle Americans may view abortion as an evil, they view it as intractable. Likewise, they view fervent campaigns to prohibit abortion as unrealistic if not counterproductive, while they are drawn to realistic alternatives and regulations. They agree that there are too many abortions and would like to see them reduced. Abortion is not a galvanizing electoral issue for Americans because they don’t believe that much can be done about the issue legally or politically. But they are wrong.

Given the state of public opinion and the fact that 75 percent of Americans believe that abortion is at least the taking of human life, if not murder itself, effectively changing public attitudes will require a shift of emphasis and resources to educating Americans about abortion’s impact on women. The most direct and effective response to the myth of abortion as a “necessary evil” is to raise public consciousness concerning the damage abortion does to women. If Americans come to realize that abortion harms women as well as the unborn, it will not be seen as “necessary,” and the “necessary evil” may be converted into evil pure and simple. In this way, we may lay the foundation for a dramatic shift in public opinion in the years ahead.

Clarke D. Forsythe, an attorney, is President of Americans United for Life.

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AMA Conscience Clause Report

The American Medical Association has set out seven principles to guide exemption of medical students from activities to which they object for reasons of conscience. The Association recommends that discussion about conflicts of conscience be part of the regular curriculum, that medical schools establish procedures to allow students to be exempted from activities for religious or ethical reasons, and that students be apprised of the policies.

It is further suggested that medical schools "define... what general types of activities" may be the subject of conscientious objection, a potentially problematic aspect of the policy. Other problems may arise in interpreting the section that requires students to learn the "basic content" of the activity in question, or in applying the seventh principle that "patient care" should not be "com-

promised." Those who consider procedures like abortion, contraception or contraceptive sterilization to be legitimate forms of "patient care" are likely to apply the principle very differently from those who do not.

However, the attempt to deal with this issue and accommodate conscientious objection is commendable, and one hopes that good faith shown by students and administration will overcome difficulties that may arise in the application of the principles.

For the text of Policy H-295.896, see www.ama-assn.org

Source: *The Protection of Conscience Project*
www.consciencelaws.org

Canadian Support for Assisted Suicide on the Decline

A recent poll by Pollara shows a majority of Canadians still favor assisted suicide, but the numbers are on the decline. When asked if they favour or oppose legalized euthanasia, 49 per cent said yes, while 37 per cent were opposed and 13 per cent were undecided.

Pollara president, Michael Marzolini, said previous surveys were conducted after high-profile assisted suicide cases that may have artificially inflated the level of support. The current poll may be a more accurate reflection of how Canadians stand on the issue.

A 1997 poll taken shortly after Robert Latimer was sentenced for killing his disabled 12-year-old daughter, Tracy, found 70 percent of Canadians said assisted suicide was allowable in some circumstances and 60 percent favored legalizing it. Only 32 percent opposed legalization then.

"This is not something that's top of mind, yet this is a good period to be taking these surveys on moral values," Marzolini said. "People have been re-evaluating their attitudes to many of these issues... The Latimer case was one that many Canadians anguished over and as a result, they had a great deal more sympathy for the issue at the time. Now we're getting more into the ethics involved in it, not the emotions."

The survey also found that in general, most Canadians avoid talking about death. When asked if they had ever discussed with friends or family the issue of a living will or the possibility of assisted suicide should they become ill, only 33 per cent responded yes, compared to 66 per cent who said no.

Source: *The Ottawa Citizen* – Sept 7, 2003

Abortion-breast cancer link suppressed by politics

A report published in the Summer 2003 issue of the peer-reviewed *Journal of American Physicians and Surgeons* (JP&S) has concluded that scientists, women's groups, and the media have consistently suppressed or ignored research that establishes a direct link between abortion and breast cancer for their own political purposes. Further, the study titled "The Abortion-Breast Cancer Link: How Politics Trumped Science and Informed Consent," found women considering abortion are not given true informed consent about the real risks of the procedure as a result of withholding this evidence.

The article discusses the epidemiologic evidence of an ABC link; the silence and denial of the National Cancer Institute, the American Cancer Society, the American Medical Association, and women's groups; media bias; the bitter opposition of pro-abortion politicians; the implications for patient care; and medical malpractice issues. A companion article documents at least 49 studies that demonstrate a statistically significant increase in premature births or low birth weight with prior induced abortions.

Author Karen Malec points out that authors of studies showing the ABC link actually denied their own findings when political heat was applied. One lead author of a record-linkage case study in 1989 worked with a group of American Cancer Society (ACS) researchers who re-

viewed the research. By then 11 of 12 US studies indicated increased risk, but she still stated the research—including her own—was "inconsistent" and that she could not arrive at "definitive conclusions."

The scientific and medical communities admit that the reasons for the suppression are political. The president of the American Society of Breast Surgeons said that she presented her concerns about getting information to the public about the abortion-breast cancer link, but the board felt it was "too political." The director of the Miami Breast Cancer Conference explained that there was no presentation on the program because it was "too political."

In conclusion, the author writes that in the end, it may be the trial lawyers, not the medical community, who force full disclosure through liability litigation against those who perform abortions without providing women with fully informed disclosure about the elevated risk.

Source: *Association of American Physicians and Surgeons* – Aug 14, 2003

The study can be found at <http://www.aapsonline.org>
or request a copy from our office.

Those Who Would Be King *The Perils of Man-Made Ethics*

Lynne M. Thompson

The Tuskegee Experiment 1932

Six hundred black men from Tuskegee, Ala. . . .
. . . knew about free transportation to local hospitals.
. . . knew about and enjoyed free hot lunches.
. . . knew about free medical care.
But they didn't know they had contracted syphilis
or that a cure was being withheld from them.
Didn't even know they were guinea pigs in a
government-funded research project.
Someone had decided that was okay.

It wasn't until 1972, 40 years after the Tuskegee Study first began, that *The New York Times* revealed the horrors of ethics gone awry. These 600 men were the unknowing subjects of government-sponsored human experimentation. Some of the men who contracted syphilis were denied treatment for their disease so that scientists could determine from their autopsies what the disease does to the body. Officials of the Public Health Service had previously investigated the Tuskegee Study and determined that scientific value justified the abuse.

Americans were shocked. Something needed to be done. America wanted ethics with their medicine. Surprisingly, they decided to purchase it from their government. Shortly after this event the government appointed an 11-member national commission (1975), mandated by the National Research Act 1974, to identify basic ethical principles to be used regarding the use of human subjects in federally funded research. The committee came up with three basic ethical principles for bioethics: respect for persons, justice and beneficence. The professional field of bioethics had officially arrived.

Birthing bioethics

Dr. Albert R. Jonsen in his book *The Birth of Bioethics* (Oxford University Press, 1998) defines bioethics as "the systematic study of moral dimensions—including moral vision, decisions, conduct and policies—of the life sciences and health care..." The 1998 Encarta Encyclopedia defines bioethics as "the study of moral issues in the fields of medical treatment and research." What Americans do not realize is today's definitions are packaged in federal ethics programs that have preconceived agendas about how ethics should be implemented.

Jonsen is quick to point out that bioethics did not begin with a big bang but rather emerged as a response to the ethical challenges posed by new science and medicine. Although the discussions of ethics in medicine predate philosophers such as Immanuel Kant, Plato and Hippocrates, from where we derived the Hippocratic Oath to "do no harm," current events in our own era created

public awareness as to why ethics in medicine was an issue to be debated.

War crimes committed during World War II demonstrated the potential of man to use governmental ethics to impose inhumane medical interventions upon an undesired group of people. The Nuremberg Code, consisting of 10 directives guiding ethical human experimentation, was eventually introduced by an American physician to the United States Counsel for War Crimes in an attempt to prevent future attacks against human subjects. Safeguards such as "informed consent" were supposed to be implemented in hopes of avoiding future atrocities.

The national commission following the Tuskegee report was the beginning of many congressionally and federally appointed bioethics commissions. Today we have entities like the National Bioethics Advisory Commission, The National Institutes of Health and, most recently, the Ethical, Legal and Social Implications programs, which attempt to serve as the conscience of the American people regarding ethics in medicine and research.

Who are the gods?

The 1981 movie *The Gods Must Be Crazy* featured bushmen of the Kalahari Desert who lived a simple life until one day when an empty Coke bottle was dropped from a plane overhead. These uneducated people attributed the bottle to a gift from the gods and assumed that it must be good; after all, the gods give only what is good.

Unfortunately this mentality fits how many Americans view governmental bioethics committees. However, it may surprise the average American to find out who the gods really are. Dianne Irving knows them. They were her professors.

Dr. Irving was the first generation of bioethicists to graduate from the Kennedy Institute of Ethics at Georgetown University. Since she already had extensive coursework in philosophy, it took her no time at all to discover things were not right in the land of the elite.

"I knew in my first class there was something very wrong with this picture. When I walked in and heard the professors describing what Aristotle, Plato and Kant had supposedly said, it didn't sound right to me. It wasn't what I had learned."

Dr. Irving wasn't the only one who noticed discrepancies. "Within six months, 28 of 36 bioethics grad students came together and formed the Square Circles Club on campus. We knew academically the historical account was wrong."

Later Dr. Irving realized that philosophical and scientific facts weren't the only thing her professors were redefining. "The National

Commission Bioethics principles definitions were rapidly deconstructed. Respect for persons changed into a 'utilitarian form of autonomy.' Beneficence for the good of the patient became 'beneficence for the good of society.' "

These redefinitions would later have a great impact on life issues, allowing for the destruction of the nonautonomous unborn child and euthanasia for the good of society. According to Dr. Irving it was the beginning of the secularization of the sanctity of life.

This disregard for truth and integrity does not surprise Father Joseph C. Howard Jr., M.Div., director of the American Bioethics Advisory Commission, a group that evaluates ethical principles from a pro-life viewpoint. "Too often today the groups are stacked. I've served on numerous bioethics committees in hospitals and medical schools with people who were mostly picked because of their politically correct views. There's a lot of rubber-stamping on what will help the doctors and the hospital."

The Rev. William E. Nebo, a "pro-choice" Presbyterian pastor, twice has been chosen to serve on ethics committees for the Human Genome Project. Nebo believes it's up to the American people to ask themselves: What eugenics principles do they feel comfortable with? When given information about genetics and population, what do people want to take a risk with? How do attitudes affect their choices? "They need to realize they could be one of those who affect the whole gene pool. Do people care far past their time enough to make those wise choices? I would like that kind of research," Nebo says.

It's this kind of research that worries Father Howard. "It's the greatest good for the greatest number. If it will generate money and save lives then they will use any means to accomplish the end. They will lie, cheat, steal and kill as long as they get what they consider a good end result. We haven't learned from history. We are repeating what went on in Nazi Germany."

The Rev. Nebo was right about one thing when he said, "I wouldn't want people to treat a committee as though it had some godlike authority or wisdom." Good thing, because in view of what we have seen so far, they don't. Before we blindly accept the recommendations of a utilitarian and amoral bioethics committee, we might want to revisit the sins of past generations, when man tried by his own goodness to decide what was right.

It's not a pretty sight.

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For complete article, see

www.family.org/physmag/issues/a0019824.htm