VITAL SIGNS

CANADIAN PHYSICIANS FOR LIFE NEWSLETTER

Spring 2003

The privilege of helping a discouraged pregnant woman

Dr. Will Johnston, MD

A family doctor in a modern Canadian city helps people out of all sorts of scrapes but few of those are immediately life threatening. Rarely can the doctor slump into his or her armchair at the end of the day after a direct involvement in truly life-saving care. When I worked in emergency rooms early in my career, death was near and had to be cheated daily, but general practice is made of quieter stuff. Quieter and less desperate, that is, until an unhappily pregnant woman arrives and suddenly, in my head and my heart, the klaxons sound and the alarm bells ring for this woman and her baby, whose life hangs by a thread.

The abortion-on-demand system stands ready and waiting. In the thousands, children are torn away and women deposited on the sidewalk with a few new statistical probabilities:

- an all-cause mortality rate for the next year over 3 times higher than if she had kept her baby
- a suicide risk over the next year 6 times higher than if she had kept the baby
- a lifetime breast cancer risk at least 2 times higher than if she had kept the baby
- a 60% higher risk of dangerous premature delivery in a future pregnancy than if she had kept the baby
- a 100% guarantee that she has forever lost her baby. And this, obvious as it is, will in time be the deepest wound for many.

Knowing this, and knowing what will happen to this distressed mother and her imperiled child if they fall into the wrong hands, I try to listen very carefully and to understand the woman's world as she is living through it.

I think of one new immigrant, with a small child at home, who could not imagine coping with another and whose nausea was clouding every day of her early pregnancy. Without much hope myself, I urged her to take a safe anti-nausea drug, to have hope for her son's new brother or sister, and to have confidence in her strength to carry on. After an absence of several anxious weeks, she returned with many misgivings and I had the pleasure of seeing her through an eventually happier pregnancy and a happy birth.

I had forgotten about these patients some months later when, with her one-year-old daughter in her arms, this woman reappeared. Into my hand she pressed repayment of the small and long-forgotten loan with which she had purchased the anti-nausea drug – she had found a good job – and tears welled in her eyes as she looked down at her daughter and thanked me for not sending her for an abortion. There are few moments in my career for which I am more grateful.

Another young woman came to me with laminaria protruding from her cervix, the prelude to an abortion scheduled for the next day. Gently removing the laminaria, I prescribed antibiotics and we watched and waited through the next few weeks. All went well, and a healthy baby emerged 5 months later.

The rhetoric of "choice" is the one-note-samba of the abortion crowd, and I used to naively think they all really meant it until I met the 19-year-old who told me how she had climbed off the abortionist's exam table in sudden doubt about going through with the procedure. "If you won't do it today I won't reschedule you!" he threatened, clearly annoyed at the disruption to his workflow (and income?). More words of admonishment followed. Happily, the bullying only served to strengthen my patient's doubts and her son is a fine young fellow now with several younger brothers and sisters.

I would love my colleagues to know the deep satisfaction of offering a clinic to patients where their unborn baby will be safe, despite the abortion storm that rages outside. Abortion is bad for women, is fatal for their children, and was only these scant last few decades adorned by the medical profession with an unearned and unwise toleration. It is my profession's biggest mistake bar none.

I have found that patients who cannot be supported enough to carry on with their pregnancies respect what I clearly explain my position to be, and return to me after their abortion, sometimes to share their anguish and regret, but always knowing that I still care for them. I lost track of one pregnant patient until, several months after an abortion, she finally returned to me and told me about her unhappy experience. She said: "After the abortion they asked who my doctor was, and when I gave your name, they said that I shouldn't come back to you because you wouldn't treat me very well when you heard about my abortion. So they sent me to another doctor, but I came back because you are my doctor."

Just as physicians have no professional obligation to amputate healthy limbs, we have no compelling duty to do abortions or refer for abortions. The simple fact is that the best medicine we can offer is steady support through the trying times of pregnancy and a steadfast rejection of the abortion trap. Hold to these principles, and as physician, friend, or family you will be amply rewarded by the joy which will finally follow.

This article originally appeared in CAPSS Connection, national newsletter of the Christian Association of Pregnancy Support Services. For more information see www.capss.com or contact ceo@capss.com

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.

Letters and submissions for publication are welcome. Membership is by donation. Donations are tax deductible.

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Life 2003 - Silent No More

Canadian National Pro-Life Conference

Thurs., Fri., & Sat. November 6-8th, 2003

Fantasyland Hotel, Edmonton, Alberta

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

Keynote Speaker: Dr. David Reardon, author of *Aborted Women: Silent No More*
President, Elliot Institute www.afterabortion.org

Promoting pro-abortion ignorance

Editorial by Dr. Will Johnston, President

Last week I checked out a new website promoted in a Children's and Women's Hospital newsletter as being a good information resource for teens. Clicking on the sexuality information page, teenagers are informed that abortion is "25 times safer than pregnancy and delivery" and that the suggestion of a link between abortion and breast cancer has been "proven false." Their webmaster has been misinformed.

The truth is something else. Researchers into Finland's national medical database uncovered risks published seven years ago showing over three times higher "all cause mortality" in the year following abortion compared to the year following a live birth.[1] The suicide rate alone was six times higher following abortion than live birth.[2] And the exhaustive documentation of the link between abortion and breast cancer can be reviewed at

www.abortionbreastcancer.com

It is instructive to compare our media torpor over the abortion-cancer link to the near-hysteria caused by the studies linking hormone replacement therapy to breast cancer. Reacting to tabloid sensationalism, an editorial in the *SOGC News*, March 2000, pointed out that a meta-analysis of over 50 international epidemiological studies showed no increased risk for HRT users of less than 5 years duration, and "an excess of 2,6 or 12 breast cancer cases per 1000 HRT users after 5, 10 or 15 years of use, respectively." More recently, the Women's Health Initiative study suggested 0.8 excess breast cancer cases per 1000 HRT users each year of HRT use, offset by 0.6 fewer colorectal cancers in the same group per year. This translates into one excess cancer per 5000 HRT users per year.

In stark contrast, a single exposure to abortion is conservatively estimated to increase lifetime breast cancer risk by 30 percent. And pro-choice cancer epidemiologist Janet Daling [see Dr. Angela Lanfranchi's article on page 5] stands staunchly behind the methodology of her 1994 study which demonstrated an especially high breast cancer risk in teens undergoing abortion against the background of a significant family risk for breast cancer. "That study was not a fluke!" she exclaimed to me in a phone conversation last month after a National Cancer Institute whitewash once again denied the link. An adequate expose of the NCI treachery can be seen at

www.bcpinstitute.org/nci_minority_rpt.htm

What then should we do? With your support, we will continue to question cancer care decision makers and opinion leaders about the willful ignorance and scientific misconduct which denies women the right to know about this risk. Every provincial Medicare database contains the raw data, which could further illuminate the abortion breast cancer connection, if the political will could be mustered to do the research. Sadly, abortion advocates are trying to perpetuate public ignorance, by lobbying to restrict availability of abortion statistics.[3]

Every provincial Medicare database contains the raw data… if the political will can be mustered

Finally, I seek to understand what seething cauldron of unacknowledged medical legal risk and denial-of-informed-consent litigation our own CM PA is now sitting on. The Canadian Medical Protective Association explicitly avoids setting "standards" or "practice guidelines" lest these act as a magnet for litigation, but surely it makes sense to begin a public warning process now before a class-action backlash of Hepatitis C proportions develops.

[1] Gissler M, et al. Pregnancy-associated deaths in Finland 1987-1994. Acta Obstet Gynecol Scand 1997 Aug;76(7):651-7. For details, see http://www.vcn.bc.ca/~whatsup/Finnish.html

[2] Gissler M, Hemminki E, Lönnqvist J. Suicides after pregnancy in Finland, 1987-94. *BMJ* 1996;313:1431-4.

[3] See, for example, Order P-1499, Information and Privacy Commissioner/Ontario.

In Response…

The Editor – The Medical Post
March 11, 2003

Personal responsibility the solution, not abortion

Ken Pole's "Politicians' abortion stance 'deceitful and dangerous,' " basks ignorantly below the cartoon wisdom of David Reddick (the *Medical Post*, Feb. 11).

The pathos is that here we are 30 years after Roe vs. Wade, and the "pro" and "anti" factions remain, dare I say it, poles apart, while one-quarter of all U.S. pregnancies still end in abortion. Personal choice, sure, but apply it before conception. We have the knowledge; we have the tools; we have the responsibility. Personal choice ends when the choice of another living person needs to be taken away.

If the rhetoric is to be revived, let us understand it's the left wing that ultimately disrespects the rights of individuals. The social liberals promote abortion as just one form of collectivist engineering, clinically disguised in a white coat and wearing surgical gloves. There is nothing respectful or respectable about intruding into a woman's womb to retrieve and destroy another human being.

Surely, let every mother be a willing mother and every child a wanted child. But, let us stress personal responsibility and primary prevention rather than relying on the odious work of the professional abortionists practicing secondary prevention at its worst.

Let us not denigrate the triad of federal legislators who are trying to provide non-abortion options for unfortunate women who nonetheless find themselves "with child."

Branding MPs Vellacott, Wayne and Steckle as anti-choice zealots and characterizing their arguments as disingenuous, deceitful, dangerous, dishonest and disinformative is patently unfair. Crisis pregnancy centres are more available and accessible in most parts of Canada than are abortuaries.

And with comparable government support they could be far more effective not only at solving the "problem" but at solving it in a way in which all pregnancy participants win. Nor is there any shortage of potential adoptive parents for "unwanted" newborns.

This is no fabric of lies but an indication of the depth of dedication within the pro-life community and within the caring community at large.

No one except the service providers is strictly pro-abortion. The ceaseless killing is an embarrassment to most citizens of any civilized country.

Perhaps the risk of abortion to individual women is overstated. Perhaps not.

The risk to the unborn, however, is absolute. And, nothing that Pole or any other pro-choice journalists say can change that.

Dr. James D. F. Harris, London, Ont.

Don't hide the risks

Globe and Mail Comment — February 14, 2003

The shrill denials of the dangers of abortion by letter writers Celia Posyniak and Ruth Miller (Scare Tactics - Jan. 30) are reminiscent of tobacco apologists' 1960s-era denials of the dangers of smoking.

This month's issue of the U.S. journal Obstetrical & Gynecological Survey * concludes that "a statistically significant positive association between induced abortion and breast cancer cannot be easily dismissed," and that there is an "overwhelming need" for more research on the matter. An earlier British review reached the same conclusion.

Even more stunning for abortion defenders, the authors note mounting evidence that abortion – often performed for putative "mental health" benefits – actually increases depression and attempted suicide.

Those who are pro-choice may want to shoot the messenger, but don't women have a right to hear the message?

Paul Ranalli, MD – Toronto

*** Reprints: "*Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*" Contact Dr. John M. Thorp, Email jmt@med.unc.edu Fax 919-966-6377, or request from our office.**

The realities behind legalized abortion

By Margaret C. Keresztesi

B.C. Christian News – March 2003
www.canadianchristianity.com

JANUARY 27 was the 15th anniversary of the Canadian Supreme Court decision which legalized abortion.

As a family physician who saw medical practice before and after the Canadian abortion laws, I observed several trends which were never debated or discussed in the media, or in medical circles.

First, the availability of abortion subjected young women to coercion, subtle or overt. It was in the interests of a woman's boyfriend's parents, employers and college officials that she not remain pregnant. Instead of the former effort to assist the young woman in unplanned difficulties, she was now made to feel that she was solely responsible for all the consequences of a continued pregnancy. Communal and individual accountability of others could be ignored if she aborted; the woman was acutely aware of this – and thus, far more vulnerable than the lawmakers anticipated.

I have seen many teenage girls over the years who knew in their hearts that they could not live with a decision to abort. Therefore, they chose to deny or hide their pregnancy until it was too far advanced to abort. This meant that many teens suffered from lack of early prenatal care as a consequence of the availability of abortion.

Another result was a conspiracy of silence regarding the psychological and social after-effects of abortion. Many aborted in an attempt to keep their relationship with a man, when studies showed that most relationships suffered major stress from the abortion.

Grief and bereavement have been extensively studied in the years since the abortion laws, and it is recognized that the most difficult grieving involves situations of unresolved conflicts or feelings towards the lost one.

We have advanced in recognizing the grief involved in a miscarriage and expect that bereavement care may be needed for such a couple. Paradoxically, couples who abort are expected to feel relief and to get on with life. Any expression of pain to those involved in the abortion process causes the listener discomfort and questions their own part in this pain -- and so the sufferers are discouraged from exploring their grief, and are left alone in their loss.

Medical science has learned far more about the humanity of the fetus, yet has tried to redefine pregnancy to allow for early abortion. Political rights to peaceful protest have been limited by 'bubble zone' laws, and freedom of speech has been curtailed.

The irony of the abortion situation is that it has been supported as a means of progress for womanhood. Feminism at its best entails full human equality and recognition for women. To expect that this will be achieved by the denial of full humanity to another segment of human society is to defeat all goals of full human equality. Instead, it simply denies status to a yet weaker segment of society.

Feminism cannot be achieved by denying the value of our maternity or of our children.

Margaret C. Keresztesi is a family physician in Comox, BC.

Ethics Magic: Making Cloning and Embryos Disappear

by Margaret A. Somerville

Dr. Margaret A. Somerville

Samuel Gale Professor of Law and Professor, Faculty of Medicine and Founding Director, McGill Centre for Medicine, Ethics and Law

"… the unethical cannot become ethical through its purpose."

The terms "collateral damage" (civilian casualties in war), "live heart-lung preparation" (a dying person used for research or as an organ donor), "a merciful act of clinical care" (killing a terminally ill patient), "products of conception" (an aborted fetus used for research), and "pre-embryo" (a human embryo) share an important feature. They are all examples of using language to describe certain realities which, if described honestly and clearly, would deeply disturb us ethically.

We can use language to define away an ethical problem – to spin-doctor it – to convince others, and possibly also ourselves, that we are not acting unethically. Dr. Leon Kass, chair of The [US] President's Council on Bioethics, calls it "euphemistic distortion". One very important current example relates to human therapeutic cloning. A "cloned human embryo" becomes "the product of nuclear transplantation (or transfer) to produce human pluripotent stem cell lines". This unwieldy term is then used to claim that in "human therapeutic cloning" (making embryos to make therapies), the production of cloned human embryos is not really cloning, and the embryos produced are not really embryos. It is to use language as a cloak to dull our moral intuitions.

That cloak is most powerful when it is medical. After all, medicine is based on first doing no harm, so we can feel comfortable no wrong will be done. And there is no more worthy goal than medicine's of saving and prolonging life, and relieving horrible suffering. That is strong reassurance ethically.

These strategies of "euphemistic distortion" and a "medical cloak" are being used by some Canadian ethicists who oppose the prohibition in Bill C-13 of human therapeutic cloning, that is, cloning embryos to take their stem cells.

What are the ethical problems with human therapeutic cloning?

First, cloning human embryos raises a question no other humans have ever faced: What does respect for *the mode of transmission of human life* require of us? Is it ethically acceptable to transmit human life by asexual replication, as in cloning, as compared with sexual reproduction, the only possibility up to now?

The ethicists who want to allow human therapeutic cloning simply assume that cloning is ethical, but the purpose with which it is undertaken – eg. to produce a child – can make it unethical. Therefore, they support human therapeutic cloning and oppose human reproductive cloning. Depending on their reasons for seeing human reproductive cloning as unethical – for instance, unacceptable risks, at present, to the child who would be born – they might in the future see it, too, as ethical, because they do not regard transmitting human life through cloning as inherently wrong. If they did, they could not advocate human therapeutic cloning.

These ethicists are correct that something that is otherwise ethical can become unethical because of it purpose, e.g. human medical research carried out to advance bio-terrorism. But the unethical cannot become ethical through its purpose. The crucial question is, therefore: Is transmitting human life through cloning unethical? For those who believe it is, all human cloning must be banned as Bill C-13 proposes.

But, even if cloning were ethical from the mode of transmission of human life perspective, human therapeutic cloning raises other issues. What are the ethics of transmitting human life with an express intention of killing the embryo by taking its stem cells? And, what are the ethics of transmitting human life to use the embryo as just a product or commodity to benefit the rest of us? In light of these features, what impact would allowing human therapeutic cloning have on respect for human life, in general, in our Canadian society? Paradoxically, human reproductive cloning – which the pro-therapeutic cloning ethicists oppose – does not raise these very serious ethical questions.

And on the "slippery slope" side, if we allow human therapeutic cloning, human reproductive cloning definitely becomes more feasible, and consequently more likely, even if we prohibit it, as the vast majority of Canadians believe we should.

And if cloning is an ethically acceptable way to transmit life, what about making embryos from two sperm or two ova or multiple genetic parents, or even possibly, in the future, constructing an embryo from scratch by assembling its genes? It would be much more difficult to argue these ways to transmit human life are unethical, if we see cloning as ethical, because we will have already departed from the norm that human life should only be transmitted through sexual reproduction, that is, the union of an ovum and a sperm.

And we have not yet even touched on the ethical wrongs to the particular embryo involved in human therapeutic cloning, and what respect for its life requires of us, and how our treatment of it will affect respect for human life in general. Essential as these latter enquiries are, they are not sufficient in relation to the ethics of human therapeutic cloning, *because they do not deal with the ethics of the mode of transmission of human life*. Yet much of the debate has focused only on those issues and been framed as a re-play of the human embryo research debate of the late 1980's, that is, a disagreement about the moral status of the human embryo and, therefore, the respect, if any, owed to it.

Yet another objection to human therapeutic cloning is that such an ethically sensitive undertaking can only be justified as a last resort after other possibilities, such as using stem cells from umbilical cord blood or living people, have been exhausted. That is not yet the case.

Our unwillingness to wait to explore other options, points to strong forces influencing our decisions. "Medical time" to save dying people or to relieve horrible suffering is often short and rightly a powerful impetus. "Business time" is also seen as short, is powerful, but conforming to its demands is not necessarily ethically justified. In our "economic rationalist" societies, we often view loss of opportunity to make profits – especially if the opportunities are expressly thwarted, as ethics can do – as wrongs that should be weighed in the balance against the ethical wrongs in taking those opportunities. That can lead to serious ethical errors, because these wrongs are not commensurable.

We humans are the result of 800 million years of evolution. We now have the power, in the palm of our collective human hand, to change that in nanoseconds. We have an ethical responsibility, not only to ourselves, but even more importantly to future generations, to take the time necessary – that is, "ethics time" – to act with ethical wisdom. There are, however, ethics voices urging us not to do so.

Breast cancer and abortion: the facts

by Angela Lanfranchi, MD

When I first heard of the link between abortion and breast cancer, in 1993, I thought it was a pro-life fantasy. "That's crazy," was my initial response. However, out of curiosity I changed the history form I used in my work as a breast surgeon, asking each woman the order and outcome of all pregnancies. The results surprised me.

In the first six months I had two patients in their 30s with breast cancer; one had had seven pregnancies and six abortions, the other five pregnancies and three abortions. I continued to see more and more young women with a history of abortion, developing breast cancer. Of course, I may have been witnessing a statistical fluke.

But then, in 1996, City University of New York Professor Joel Brind published his meta-analysis, which revealed 23 of 28 studies showing a link between abortion and breast cancer. The uproar that study caused in Britain, where it was published in the Journal of Epidemiology and Community Health, prompted the editor to write: "I believe that if you take a view (as I do) which is pro-choice, you need at the same time to have a view which might be called pro-information without excessive paternalistic censorship (or interpretation) of the data."

Paternalistic censorship is what I experience every time I try to speak on the science supporting the abortion-breast cancer link.

About 85 per cent of cigarette smokers do not get lung cancer. Doctors who tell their patients of the risk of lung cancer are not labelled fear-mongers. Similarly, not all women who have had an abortion will get breast cancer; only 5 per cent will develop the disease. And 95 per cent of breast cancer patients will not have a history of abortion. But some women are at especially high risk. And 5 per cent still adds up to a lot of women (See note following from author).

The 1994 Daling study published in the Journal of the National Cancer Institute showed that teenagers younger than 18 who had abortions between nine and 24 weeks had nearly a 30 per cent chance of getting breast cancer in their lifetimes. The US National Cancer Institute's web page on reproductive risk informs women there are studies that show this link.

Many people ask me about first trimester miscarriage. This is quite different, in its effect on the woman's breasts, from induced abortion of a normal pregnancy. Miscarriages do not increase breast cancer risk, since they are associated with low oestrogen levels that do not cause breast growth. However, when pregnancy is terminated before the breast cells reach full maturity, a woman is left with more immature type 1 and 2 breast lobules (milk glands) than before her pregnancy started, and therefore is at increased risk. Her breasts never mature to type 3 and 4 lobules, which would have occurred in the third trimester and would have lowered her risk.

Ideology should not prevent the dissemination of this information. Australia's breast cancer organisations are not helping women exercise informed consent when they deny them this knowledge. There are three legal actions in the US by women who were not told of the link before having an abortion.

As Dr Janet Daling, who identifies herself as being pro-choice, says: "If politics gets involved in science, it will really hold back the progress we make. I have three sisters with breast cancer, and I resent people messing with the scientific data to further their own agenda, be they pro-choice or pro-life. I would have loved to have found no association between breast cancer and abortion, but our research is rock solid, and our data is accurate. It's not a matter of believing. It's a matter of what is."

Information only empowers women to make informed choices. Women who choose abortions need to be aware that they are at higher risk, so they will have mammograms earlier and more regularly. Cancers found on mammograms are more likely to be stage 1 and curable. No woman should die of breast cancer because she was not warned.

I watched my mother die of metastatic breast cancer. In my practice, I see young women with small children die of breast cancer. If the information I give patients can prevent a single death from a completely avoidable risk, I will gladly pay the price of being labelled a fear-monger.

Feb 17 2003, *The Age*
Melbourne, Australia daily news

NOTE from Dr. Lanfranchi:
Please note that there is a glaring error in the statistics about risk in this op-ed piece. I meant to say that there would be an excess of 5 breast cancer cases that develop per every 100 abortions performed. In other words, "For every 100 women with no elective abortion history roughly 10 will contract breast cancer during their lifetime. For every 100 women with an abortion history roughly 14 or 15 will contract breast cancer."

Dr Angela Lanfranchi is a breast cancer surgeon, a fellow of the American College of Surgeons and clinical assistant professor of surgery at the Robert Wood Johnson Medical School in New Jersey.

The Debate Heats Up

J. C. Willke, MD

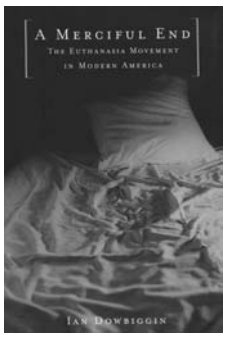
The federally funded [U.S.] National Cancer Institute has had an obvious reluctance to admit that there could be any relationship between abortion and breast cancer. This culminated in a recent seminar, which was publicized to be an open, interdisciplinary investigation, discussion and debate of both sides of the issue. Sadly, this did not happen. The invitations were carefully selected and a committed pro-abortion staff chaired the conference. There was essentially no discussion and no debate. Finally, there was a prearranged conclusion, which was voted on soon after the meeting began and overwhelmingly passed.

…The program had assigned a fairly lengthy time at the end for open discussion. The meeting, however, was abruptly recessed, eliminating that opportunity. The National Cancer Institute promptly issued its report claiming no connection. A minority report publicly offered by Dr. Joel Brind was in the end grudgingly accepted.

…this almost frantic effort by the pro-abortion industry will not close the door on this issue. The previously published scientific studies speak for themselves, political statements to the contrary. There is a link and it is proven. (Life Issues Connector, April 2003)

NOTE: Dr. Brind's report is available on his web-site at
http://www.bcpinstitute.org/nci_minority_rpt.htm or request a copy from our office.

A Merciful End - The Euthanasia Movement in Modern America

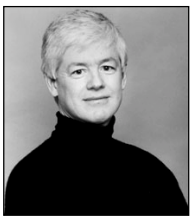


By: Ian Dowbiggin
Oxford University Press
January 2003

"A deeply researched, well-written, and admirably well-balanced book … that should engage readers interested in social, intellectual, cultural, legal, and medical history."
James T. Patterson
Professor of History
Brown University

"For anyone trying to decide whether euthanasia offers a humane alternative to prolonged suffering or violates the 'sanctity of life,' *A Merciful End* provides fascinating and much-needed historical context."
Publisher's Weekly

"*A Merciful End* is an excellent piece of research, written in the voice of a fine story-teller."
Wade MacLauchlan
UPEI president



Dr. Ian Dowbiggin is Professor of History at the University of Prince Edward Island

"Talk of a right to die raises the troubling questions: once legalized for the dying, who can be denied such a right? The chronically ill, but not dying? Pain-free patients who nonetheless feel their medical conditions leave them with no quality of life? Depressed teenagers? The mentally ill? Handicapped children whose parents wish them dead? Infants with severe disabilities? Where does the freedom to die end and the duty to die begin? The history of euthanasia in America reminds us that, despite a century of intensive debate and passionate political battles, these questions remain largely unanswered."

So concludes Dr. Ian Dowbiggin in his new book, *A Merciful End: The Euthanasia Movement in Modern America*. Professor Dowbiggin brings together a rich blend of history, information derived from the archives of the Euthanasia Society of America, political analysis, and review of public sentiment in a very readable account.

Dowbiggin's interest in the right to die movement was piqued while writing *Keeping America Sane*, a history of psychiatry and eugenics in Canada and the United States published in 1997. He writes,

… the euthanasia movement dovetailed with contemporaneous fashionable crusades throughout the twentieth century… There was a certain philosophic symmetry uniting eugenics, euthanasia, population control, birth control, and abortion reform. Practically, there were obvious links among them, such as the use of euthanasia as both a eugenic and population control method. But more importantly, what tied these various causes together was a common belief among their supporters that they were breaking what [Canadian psychologist Olive Ruth] Russell called "the stranglehold of tradition and religious dogma," the barriers that allegedly prevented individual human beings from realizing their freedom. …at the heart of Russell's liberationist agenda was the same fundamental ambiguity about the boundaries between voluntarism and involuntarism, a right to privacy and the right of the community to defend itself, that had dogged earlier generations of euthanasia proponents… (p. 134)

In an interview with Canadian Press, Dr. Dowbiggin relates that as he was researching *A Merciful End*, a close friend was diagnosed with terminal prostate cancer. "He fought the disease for three years to the very bitter end, and he just underwent all kinds of debilitating treatment, yet he refused to give in."

"Once he had passed away, I thought to myself, here was a strong-willed person with a clear sense of individual character - a rational well-educated person. What would happen if euthanasia were legalized, and how would people less educated with less willpower, more vulnerable to pressure from family and friends, feel in that position?"

"Could they be easily talked into submitting to or requesting physician-assisted suicide or actual mercy killing? If it were legal, wouldn't that put them in a vulnerable position?"[4]

This experience taught the author that death and dying were not purely personal matters. "It also taught me that there is no such thing as a right to die."[5]

A Merciful End provides fascinating historical context to the current wide acceptance of living wills and the embracing of improved end-of-life care, while physician-assisted suicide laws have succeeded only in Oregon in spite of polling data showing wide support. Dowbiggin notes that although Americans endorse a generalized and abstract right to die, when asked questions about specific medical situations, public support declines. Support for physician-assisted suicide is neither strong nor deep.

Dowbiggin believes that "The future of the euthanasia movement will ultimately depend on how the debate over self and society unfolds in the present century, how the tension between the search for a boundless individualism and the quest for a meaningful community is resolved."

Let us hope that as his fellow Canadians continue to define a national identity and meaning of community we conclude with Dr. Dowbiggin that legalizing euthanasia, either as physician-assisted suicide or actual mercy killing, is a bad policy decision.

"We need to understand fully what we are actually getting into. Because once it's legalized, do we just say, 'That's it, no more. We're not going to extend the boundaries any further.' Can we do that?"[6]

Reviewed by Janet Les

[4] Mackay, Mary (February 2, 2003). *Legalizing euthanasia would set dangerous precedent, says author.* The Halifax Herald.
[5] January 28, 2003. The Journal-Pioneer.
[6] Mackay

Deadly milestone: 5 years of assisted suicide

American Medical Association News
Editorial. April 21, 2003

Oregon marks its fifth year as the only state in the nation to allow physician-assisted suicide. The number of people availing themselves of the law in 2002 doubled since 1998, the first year the law was in place.

Oregon marked a somber anniversary last month when officials released the fifth annual report on physician-assisted suicide under the state's Death with Dignity Act.

For those who believe, as the AMA does, that physician-assisted suicide is fundamentally inconsistent with a physician's professional role, the report is troubling.

While the number of actual suicides under the law remains relatively small – 38 in 2002 – that number is more than double the 16 suicides that occurred in 1998, the first year the law was in place.

Also troubling, as it has been in the past, is the report's findings on the reasons people contemplate physician-assisted suicide.

It would be easy – and, many would say, understandable – if intractable pain, a traditional rallying cry for assisted suicide, was at the forefront. Not so. It came in, as it typically does, very near the bottom of the list. Instead, the main reason has remained constant: loss of autonomy.

Joining it at the top of the list are concerns over decreasing ability to participate in the activities that make life enjoyable, losing control of bodily functions and becoming a burden on family, friends or caregivers.

This represents both a tragedy and a challenge for the medical profession and for society. A dignified and pain-free end of life – without perverting medicine's mission – is achievable. The medical profession needs to do its share, both clinically and in terms of advocacy, to ensure that dying patients are provided optimal treatment for these discomforts, physical or emotional.

With at least two more states contemplating legalization of assisted suicide, it is important that the future debate not surrender to the failure represented by each deadly prescription.

http://www.ama-assn.org/sci-pubs/amnews/amn_03/edsb0421.htm

Why Oregon assisted suicide is on the rise

The Washington Times
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Within five short years, the number of persons killing themselves with lethal prescriptions in Oregon has reportedly doubled. Whether or not that breathtaking increase accounts for all medically induced deaths in the state, we'll never know. Here's why:

1. Oregon's assisted suicide law actually prevents concerned citizens, the media or watchdog groups from examining individual cases. The law stipulates that "the information collected shall not be a public record and may not be made available for inspection by the public." With Oregon's healthcare reputation on the line, can we really expect assisted suicide scandals to show up in the state's sterile statistics?

2. Where assisted suicide and euthanasia have been legalized elsewhere, as in the Netherlands, it has produced a culture of lethal arrogance within the medical profession. Studies reveal that Dutch doctors give lethal injections to roughly a thousand patients a year with no explicit request to do so from the patients. I have personally interviewed still-grieving family members whose loved ones tragically lost their lives to a runaway medical system sheltered by a euthanasia-entrenched government.

3. Financial inducements strongly favor ending a terminally ill patient's life prematurely. Don't expect health insurance companies, state health insurance bureaucrats or unscrupulous heirs to lobby for palliative care when assisted suicide gets right to the bottom line.

The secretive suicide scheme in Oregon poses a dangerous departure from democratic principles and government protection of its most vulnerable citizens. In light of the tragic euthanasia purges of last century, the notion of state-sponsored, medically induced death under a veil of secrecy should be anything but comforting.

Jonathon Imbody, Senior Policy Analyst
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Repression of Conscience

A lesson from healthcare professionals in other countries can prove instructive for American doctors wondering what the future might hold regarding conscientious objection. In the Netherlands, for example, where "end of life services" spells euthanasia, physicians who abstain from the practice for the sake of conscience can pay a high price.

According to Peter Hildering, M.D., a family physician and leader of the Dutch Physicians Guild, Dutch Christian physicians and medical students find themselves in the "lions' den" of medical ethics challenges. Hildering says that his organization is receiving reports of discrimination against Christian physicians who buck a healthcare system that aggressively advances abortion and euthanasia.

"The position of doctors who don't want to perform euthanasia in Holland has become difficult," Dr. Hildering notes. "We surveyed our members to see if they met problems [of discrimination]. We heard both from nursing home physicians and GPs that there were problems in finding a place in which to practice. Students who want to specialize get questions about whether or not they want to work with euthanasia. And if not, in some places they are not welcome. It's the same thing with gynecology and abortion."

Dr. Hildering illustrates the problem with examples. "A general practitioner I know of says he doesn't want to work with doctors who don't perform euthanasia. He worries that the patients of the [conscientious objector] doctor will all come to him for euthanasia – and he's not happy with that. One of the groups in a rural area had a visit by the inspector for health because one of the doctors wouldn't perform euthanasia in that group. And he put it to that group of doctors that they had to look for a way for their patients to get euthanasia because he felt it was a normal medical practice to offer."

Dr. Hildering points to an ironic fact that keeps the lions at bay for now. "What helps protect us is that there's a shortage of doctors in Holland—that's the only reason. If the shortage is met, then I think the problems will occur very rapidly."

Excerpted from "A national battle over healthcare ethics threatens to put any conscience-guided Doctor in the Lions' Den" by Jonathan Imbody, *Today's Christian Doctor* – Fall 2001.

For complete article, see: www.cmdahome.org

For resources and information on conscience issues, see http://www.consciencelaws.org

Knowledge of Fetal Development and Fetal Pain Grows over Last 10 Years

By Paul Ranalli, M.D.

Question: When does a decade seem like 700 years?
Answer: When one considers the evolution of public awareness of life in the womb over the past 10 years.

In the 1300s, a new life was judged to have begun when a living, breathing baby emerged completely from her mother's womb. This "born-alive" rule was thus established as the first point of a person's legal protection, a standard that was entirely justified and logical, given that it was a product of the best scientific evidence at the time. They simply didn't know any better.

Flash forward to the late 20th century when, paradoxically, the scourge of widespread abortion in the Western world emerges against a backdrop of accelerating knowledge of the remarkable degree of human development in the womb. The last decade, in particular, has witnessed striking advances in our knowledge of fetal life.

Yet the legalized practice of abortion, and the related denial of rights to unborn victims of violence against the mother, holds fast to a legal standard based on the scientific knowledge current at the time of Henry IV: the venerable "born-alive" rule. Pro-abortionists, once admired by the media as the vanguard, now bring up the rear, clinging to "science" seven hundred years out of date.

But a once tiny rent in the fabric of the case that denies the unborn her humanity has now spread, threatening to rip this lie apart.

The evidence that the unborn is "one of us" is virtually everywhere in popular culture.

You see it while you wait in the grocery line–the front covers of magazines which feature marvelously detailed photos of prenatal development–or as you surf across the dial and run into that unforgettable commercial showing a mother positively captivated by the 4-D, full-color ultrasound of her unborn child.

There are two major advances responsible for a growing respect for life in the womb. One is ultrasound; the other is an understanding of brain development, especially the capacity of the unborn to experience pain.

In thousands of ultrasound labs and prenatal clinics across the country, mothers and fathers undergo their own personal epiphany each time the first hazy image of their unborn child comes into view. In some cases, it is an unwed mother in a crisis pregnancy, undergoing a confirmatory staging ultrasound before a planned abortion.

But how can this be? she asks herself. I was told "it" would just be a blob of tissue, yet there is this beautiful creature sucking her thumb, hiccuping, flexing her stubby arms. And so it goes, as another mother begins to bond with her baby months before the birth event. The odd couple of modern radiology and age-old Mother Nature combine to trump the received wisdom of political correctness.

The exquisite color images of the developing human by photographer Alexander Tsiaras in his new book *From Conception to Birth: A Life Unfolds* were recently splashed on the cover and pages of *Time* magazine. "Inside the Womb" reads *Time*'s cover.

"An amazing look at how we all begin" coyly tiptoes around just when in the sequence we actually do begin.

But in a "pro-choice" media world it is a revelation to read an article that leads off with a mother gushing over the natural behavior of her 17-week-old unborn child who, after maturing for another month, would be a candidate for a partial-birth abortion. When the article declares: "Although it takes nine months to make a baby, we now know that the most important developmental steps . . . occur before the end of the first three" –how many make the connection that this is the prime period of most "elective" abortions?

Less visible, but no less remarkable, is the depth and complexity of the unborn child's early brain development. Even before a woman usually knows she is pregnant, the embryo inside her womb will have begun to sprout a hollow bulge–the rudimentary brain.

At just five weeks, the smooth brain begins to fold into the familiar surface convolutions that ingeniously add surface area for more brain cells. By nine weeks the fetus reacts to noises and can hiccup. Shortly after, she can suck her thumb. Premature newborns can clearly hear, and babies still in the womb in the late second and third trimesters have been shown to prefer their mother's voice to others, and to recognize a familiar bedtime story over other texts read aloud.

Johns Hopkins researcher Janet DiPietro has shown evidence that fetal temperament can predict a baby's behavior after birth. In 1998, DiPietro told one publication that,

"birth is a trivial event in development – nothing neurologically interesting happens."

A backhanded compliment to the complex early development of the unborn brain was provided, ironically, by fetal transplant researchers throughout the 1990s. They proposed reversing the brain degeneration of patients with Parkinson's disease by stripping the midbrains of eight-week-old aborted fetuses of the cells that produce the chemical whose absence is thought to cause Parkinson's–and then transplanting these cells deep into the Parkinson's patients' brains.

The experiments not only failed, as such unnatural ventures are prone to do, but they ultimately caused ghastly and uncontrollable movement side effects. Nevertheless, the scientists were right about one thing. The tiny unborn brain at eight weeks does already contain midbrain cells that are able to produce the chemical dopamine, which is responsible for some of the more refined, sophisticated forms of adult voluntary movement.

The last decade also taught us much about the unborn child's ability to sense and react to its environment. One way we sense the outside world is our ability to perceive pain. The concept that an unborn child feels pain during a late-term abortion went from being rudely dismissed by abortion supporters to being frankly acknowledged by British abortionists themselves.

Elevated stress hormones–the same as those released by adults in pain–are found to be massively elevated when a painful blood extraction procedure is performed on unborn babies as early as 18 weeks. An automatic protective response to pain occurs in fetal brain circulation at just 16 weeks' gestation. More alarmingly, newly discovered brain chemicals devoted to pain perception (Substance P, enkephalin) have now been detected in the fetal brain as early as 11 and 13 weeks.

Since premature newborns at 23-24 weeks have been observed to feel pain, even more strongly than full-term newborns, this is clearly the outside limit of when an unborn baby can detect pain. But what is the earliest moment of pain detection?

The above evidence suggests that 20 weeks is a conservative estimate. English fetal pain researcher Dr. Vivette Glover, who is personally "pro-choice," has stated: "I think the evidence is that the system is starting to form by 20 weeks, maybe by 17 weeks."

Of course, the British gynecologists who accepted the fetal pain findings, including that of Dr. Glover, did not conclude that unborn babies should be spared an unimaginably painful elective death. Rather, they called for doomed second-trimester infants to receive anesthesia before being executed. While abortion supporters have their stalwarts who will not be shaken by such a concept, you can just feel the movement of opinion among a huge segment of middle-ground people, whose threadbare tolerance for unrestrained abortion is reaching its limit.

National Right to Life News – Jan 2003

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