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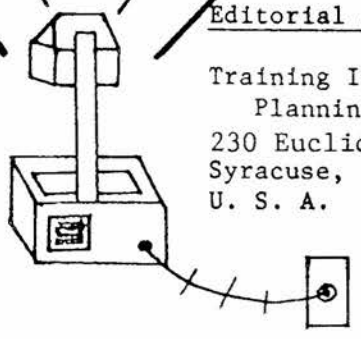

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Please note that TIPS (and indeed the entire Training Institute) now has a new address, shown on the masthead and on the last page of each issue. All correspondence about subscriptions should be sent to the new address.

The issue of TIPS dated 2, 4&6/97 had an incorrect bibliographic identity on the face page that slipped by proof-reading. Some copies were hand-corrected before they were sent out, but many were not. In case your copy was not corrected, you can do so yourself. The correct information for that triple issue should have been Volume 15, Number 5, February 1996; Volume 15, Number 6, April 1996; Volume 16, Number 1, June 1996.

The major theme of this triple-issue is the risk to life of societally devalued people, or what we call "deathmaking," i.e., the abbreviation of life by whatever means, including indirect and long-term ones. Our last major coverage of this theme was in the 4/96 issue. Some of our items are a bit dated because of long intervals between deathmaking issues, but as long as they illustrate dynamics that are still ongoing, they are as relevant now as they were a few years ago.

Subscribers who think that this issue has too much material on deathmaking should ask themselves: If one had lived in a society that killed 1.5 million Jews a year for years, would it have been excessive to bombard its citizens with masses of material opposed to Jew-killing?

We would appreciate readers' feedback to any or all TIPS issues.

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The Abortion Scene

We will divide items on the abortion issue into several sections.

Abortion: Deceitful Interpretation as Contraception

As we repeat endlessly, it is a fundamental cosmic truth that wherever there is violence, deception abounds. One of the deceptions about abortion that seems to have no end is that certain forms of abortion are not abortions at all, but acts of contraception. For anyone who still doubts

that so-called contraceptive pills do not also cause abortions, we recommend the in-depth research on this issue reported in the 9/97 issue of Life Advocate.

*Even Time (15/7/96) finally admitted that oral "contraceptives" also function as abortifacients, as a back-up to their contraceptive action.

*The abortion lobby has succeeded in having post-coital abortifacients interpreted as "emergency contraceptives" (e.g., Health Letter, 4/97).

*RU-486 is sometimes interpreted as an abortion drug, and sometimes as a post-coital contraceptive. However, other drugs that almost always function as abortifacients are almost always interpreted as post-coital contraceptives. Among these are drugs that in small doses act usually as contraceptives, but in large doses act as abortifacients (Time, 15/7/96).

*Science (31/5/96) reported that failure to use contraceptives "leads to over 50 million abortions a year" in the world. Insofar as contraceptives cause millions of abortions each year, this is like saying that attempts to abort lead to abortions.

*The abortifacient "contraceptive" drug Depo-Provera is being offered to high school girls through their schools' "sexual health centers" (Interim, 10/97). Warnings that accompany the ads for the "contraceptive" Depo-Provera inform us that the drug can cause cancer and paralysis, but apparently these are preferable to having a baby--and certainly so if one is giving the drug to somebody else.

*One irony is that Norplant, as well as a whole array of other "birth control" drugs and devices, is made by American Home Products which bought A. H. Robbins after it went bankrupt in consequence of the many lawsuits about its Dalkon Shield IUD. One of the side effects of Norplant is that it causes blindness, which is rather symbolic. One can say that women everywhere have been blinded by what all abortifacients interpreted as contraceptives are doing not only to their unborn babies but also to themselves (CL, 7/96).

*Manufacturers of "birth control" pills have begun to promote their use among teenage girls with a promise that these pills will help them to avoid, or clear up, acne. One company has advertised these pills as a "beauty pill." The advertisements show beautiful young models with perfect complexions, often inserted in college newspapers together with a $5 coupon toward a first purchase. Some advertisements say in so many words that a single pill can not only prevent pregnancy but also make one look beautiful at the same time. (If true, it would of course attract even more male sexuality upon oneself than the one that made one try to avoid pregnancy.) Other benefits promised are reduction in menstrual discomfort, regulation of cycles, and lowering of risk of cancers, cysts, and pelvic inflammations. One ad says that this pill is "a good choice for women 15 and older" (note that when young females are pushed into sexuality and abortions, they are called "women," and when they are exploited by men, they are "girls"). The president of the Foundation for Developmental Endocrinology announced this to be "great news." Critics charged that it is a way of getting girls on oral contraceptives while giving them the impression that they are taking the pill primarily or exclusively for their looks. Not mentioned to prospective users is that all contraceptives can actually cause acne; and the news that all the other afflictions that the advertisements say the pill combats are actually among the side effects is presented in barely-readable small print. Also not mentioned is that these pills have a back-up abortifacient effect. Ads have been run in periodicals such as Glamour and Shape (NC Register, 24/5/98).

*One used to be able to say correctly that human life begins at conception, but now that the pro-abortion lobby has changed the definition of conception (to mean implantation), in order to make early abortion by various means appear less objectionable, one may be unwittingly playing into its hands unless one says that life begins at fertilization.

*A long article on "benefits and risks" of "birth control pills" in the Syracuse Herald-Journal (11 Oct. 96) was very typical of the prevailing propaganda. The benefits list was almost three times as long as the risk list; the risk list did not mention the abortifacient effect; but it was claimed in fat print that the risks listed were lower than formerly because the pills were no longer as strongly formulated as they used to be.

Abortion: Other Deceits

*In their moral confusion, modernistic people have fewer compunctions about having abortions the earlier during pregnancy the abortion takes place. In their minds, an unborn baby obviously becomes a "realer" baby from day-to-day. The pro-abortion people have been capitalizing on this mentality by trying to push forward as far as possible both the detection of pregnancy, and the abortion methods.

A 21 December 1997 news item, and another dated three days later, announced a new (or at least newly disseminated) abortion technique that was said to "rewrite the book on abortion." Invented by a physician at Planned Parenthood (PP) in Houston, TX, it uses a syringe to perform the abortion as early as 8 or 10 days after conception. (Newly-developed "ultrasensitive" pregnancy tests can apparently detect a pregnancy this early on.) Abortion advocates claim that this is a preferable method of abortion because "...we're talking about a...gestational sac that's the size of a matchstick head. It's nobody's picture of a little baby sucking the thumb," referring to the fact that an unborn child looks so much like a born one, that abortion foes have been successfully showing pictures like this everywhere, and that these pictures make many women more reluctant about having an abortion.

This ploy to make people more willing to abort right away is similar to other successful efforts to confuse contraception mechanisms with abortifacient ones. For example, the main mechanism of both the drug RU-486 and intra-uterine devices (IUDs) is to prevent implantation of the fertilized egg, and this mechanism is being interpreted as "blurring the line between contraception and abortion" (Syracuse Herald American, 21 Dec. 1997, pp. A1 & A11, and Syracuse Herald-Journal, 24 Dec. 1997, p. C3). Of course, it does no such thing. Those who want to confuse the issue in order to make abortion seem less objectionable merely claim that the two are virtually the same, and that the earlier in a pregnancy an abortion is performed, the less worse it is--"the sooner the better," as a PP spokesperson put it. Another pro-abortion advocate said that this makes "a seamless web" of contraception and abortion--the very thing that the Catholic Church has long taught, but that has been vociferously denied even by abortion opponents who did not want to be seen as Catholic or allied to Catholicism. It is also an allusion (in counter-image) to the "seamless garment" ethic of opposition to all forms of deathmaking, including "euthanasia," abortion, and war-making, that has been proposed by some Christian ethicists.

It is also remarkable that the first item on this topic appeared in the newspapers on the same Sunday that in Catholic churches around the world, a passage was read from scripture in which Elizabeth (pregnant with John the Baptist) tells Mary (pregnant with Jesus) that "The moment I heard your greeting, the baby in my womb leapt for joy" (Luke 1:44), and three days before the feast (Christmas) that commemorates the birth of a child under circumstances that many people today would say justified an abortion.

*With more and more medical bodies and entire countries having legally redefined conception, the onset of pregnancy, or the definition of the embryonic state as being somewhere between the 4th and the 14th day after fertilization (and everything earlier to be "preembryonic"), Germany and Austria are among the last countries left that still acknowledge that new life starts at the moment of fertilization--the same as in mice, chicken, horses, swine, etc.

*By the time readers get this, a "morning-after" kit, called PREVEN, should be on the market. The name suggests "prevention" (i.e., of pregnancy), but should really have been called ABORTEN.

*We saw the senior officer of Planned Parenthood (PP) interviewed on CBS TV news in September 1998. The interview interpreted the new "morning-after" pill as a "contraceptive." When the PP woman was asked about the "1 million fetuses" aborted the previous year in the US, she broke into a bright smile.

*In light of the context of unrelenting deception and language games, one potential development to watch for is that a pregnancy may be interpreted as a "molar pregnancy." In such pregnancies, the ovum loses all of its nucleus before fertilization, or the maternal portion after fertilization, but a placenta develops nonetheless, implants itself, mimics pregnancy, and eventually causes severe problems that can even endanger maternal life. Treatment consists of suctioning out the implanted tissue (Discover, 7/96). This is very similar to an abortion, and this is why one must be certain one is not told that a pregnancy is a molar one when, in fact, someone is trying to get one to have an abortion.

*The New Republic, a flagship periodical of the liberal left, referred to late-term babies being aborted by the partial birth abortion method as "fetuses (who) more closely resemble... the babies they'll eventually become," despite the fact that almost all these abortions are performed on babies who would be viable outside the womb (NRLN, 11 June 96).

*When the partial birth abortion first became public, the abortion people said that only a few hundred had taken place, but even Time (21/10/96) was ashamed to eventually admit that it had misreported, and that the number was vastly greater.

In fact, the head of the National Coalition of Abortion Providers admitted publicly that he had "lied through my teeth" about who was getting partial birth abortions, and why, and how many. "I just went out there and spouted the party line" (SHJ, 28/2/97). Other abortion advocates (e.g., the Planned Parenthood Federation of America) quickly claimed that his confession was a lie (SHJ, 4 March 97).

*Earlier, we noted that the same female may be interpreted as a "girl" in order to put men into a predatory light, and at other times as a "woman" who is a mature self-determiner who can decide without anyone's interference whether to have an abortion. For instance, Time (2/2/98) referred to Monica Lewinsky as "a girl, a few years older than his (President Clinton's) daughter." Similarly, Newsweek, (2/2/98)--i.e., on the very same date as Time--referred to Lewinsky, age 24, as "a young girl."

*It has come to light that Norplant has been inserted in girls down to age 11, in some instances in order to keep it a secret that the girls were being sexually abused by male family members (LA, 1/97).

*Apparently, the data that suggest that RU-486 is relatively safe are based on studies that carefully excluded any women with risk factors, including even smokers (NRLN, 7 May 98).

*There is only one product legally made in the US where the manufacturer's identity is being kept secret: the US maker of RU-486 (NC Register, 2 March 97).

*Pro-abortionists have always denied that the unborn baby feels any pain while being aborted. For instance, when President Reagan said in 1984 that many babies felt pain during abortions, he was viciously attacked by numerous parties, including by the President of the American College of Obstetricians and Gynecologists who have now reversed themselves. Yet another of a series of revelations embarrassing to the abortionists is that a British commission of obstetricians and gynecologists has recommended that at the very least upon the 24th week of pregnancy, babies about to be aborted should first be anesthetized, which however is of course a rather perverse form of mercy (NRLN, 18/11/97).

forced to stop smoking; and if I have a right to an abortion, then force can be used to compel that all sorts of abortion-related services be provided.

*Japan has been called "abortion haven," but no one there seems to be willing to speak openly about the custom (since ca. 1970) of using abortion as birth control. But rather than denying that babies are being killed, Japanese language speaks of "returning" children. Even though there is virtually no public debate on the issue, a great many people who engage in abortion feel bad enough about it to hold a special ceremony of apologizing to the "returned" babies. The Buddhist cult particularly has special rituals for this purpose (FT, 10/96). For instance, Japanese women who have had abortions commonly leave infant-sized stone or plastic statues--called jizos--at Buddhist temples to guard the souls of the dead babies against demons. These jizos may cost up to $1,000. They may also dress the jizo, leave toys, and write notes expressing their grief and regret. There is one thing they will not do, and that is pretend that no baby was involved, and no killing took place.

*Under other headings, readers will find yet additional reports of deceptions about abortions.

Abortion: Prenatal Testing

*Women keep reporting that they are under incredible pressure to have prenatal tests, and if the results suggest the possibility of having an impaired child, they come under pressure that many of them find irresistible to have an abortion. Many women have used language that they were "forced" to have an abortion. For instance, of those British women who consented to take a prenatal test for fetal abnormality, and then further consented to an abortion if the test suggested the child might have Down's syndrome, three-quarters said that they were "more or less forced" to have an abortion by health personnel (Weekly Standard, 2 Dec. 96; source item from Irene Ward).

*Of 22,000 women who received prenatal diagnosis in a 1990 study in Canada, 88% who were told that they would have a child with Down's syndrome had an abortion. Other studies have put the abortion rates as high as 90% or even higher (Weekly Standard, 2 Dec. 96; source item from Mel Knowlton).

*A mother who had a child with Down's syndrome that somehow slipped through the prenatal deathmaking net sued for damages saying, "Life isn't easy for those of us with all of our mental capacities. I would have loved him enough not to have him" (Culture Wars, 12/97, p. 48).

*On its very cover, the Weekly Standard (2 Dec. 96) commented on the irony that "It is one of the triumphs of modern society that the life of the average person with Down Syndrome has become strikingly normal. Except that, unlike normal people, babies with Down Syndrome have been targeted for elimination." (Source material from Irene Ward.)

*It was reported with great satisfaction that infant deaths due to birth defects had dropped by 34% between 1980-1995, but what was not included in the report was that this is largely due to prenatal screening and abortion (AP in SHJ, 25/9/98).

*A hospital in Vancouver has ceased telling women the sex of their unborn baby that had been determined by a sonogram because too many women decided to abort when their baby was of the "wrong" sex (BRMM, 9/97).

*A letter-writer to First Things (3/95) said that prenatal testing for birth defects was not an expression of "prejudice," as in testing for the child's sex in India, but a use of "objective knowledge" that raising a defective child is a "horrendous burden to the parents," and that it is therefore "preferable to abort the fetus before it becomes a child and try again."

*We continue to warn people that prenatal testing for abnormalities in unborn babies sometimes comes up with the craziest dire predictions of such impairments which not infrequently are then disconfirmed upon birth--provided the mother did not let herself get buffaloed into an abortion (NRLN, 24/2/97).

*The earlier in pregnancy amniocentesis is performed, the higher is the risk that a miscarriage is induced, or that the unborn child will be deformed. Nonetheless, there has been a trend toward earlier amniocentesis (Time, 9 Feb. 1998). Chorionic villus sampling is supposed to be safe--but that is what they used to say about amniocentesis.

*A new abortion method is the administration of vaginal ultrasound which works as early as in the 8th week of gestation (Nswk., 26/1/98). If this is a killer at that age, one wonders about damage that might be inflicted by ultrasound imaging for prenatal testing later in gestation.

*Prenatal testing overwhelmingly serves to promote abortion. However, there is an exception. The abortion lobby has complained bitterly that "fetuses have become humanized," especially by sonograms which expectant parents routinely carry about or tape to their iceboxes (Newsweek, 26/1/98).

*In 4/89, we saw our first invitation to a baby shower "in honor of the pending arrival of Little Miss so-and-so." In other words, the sex of the baby was announced prior to birth, probably as a result of a prenatal test that might have led to an abortion if the child had been handicapped--or possibly even of the wrong gender. Or was the prenatal test for sex only done so as to be able to tell invitees to the shower what sex the baby would be?

Abortion: Supporters & Proponents

*It is a peculiar incongruency that the very people who do not believe in freedom of will have been exalting the construct of "freedom of choice."

*UN agencies increasingly are moving toward giving ever more support to contraception, sterilization and abortion. For instance, one UN working group proclaimed that abortion should be available in all UN refugee camps at all times (NC Register, 19/10/97). Even Unicef, which most people associate with child saving, has begun to promote "morning after" abortion drugs and liberalized abortion laws in some nations, in addition to disseminating (pardon the expression) contraception (SHA, 10 Nov. 96).

*According to some people, Canada has the most pro-abortion public policy of any Western country (NC Register, 8 June '97).

*Over the years, the US government has consistently allocated vast sums for population control (including abortion) in poor countries. Apparently, the reasoning is that the fewer people there are elsewhere in the world, the better off the US will be. For 1997, $385 million was allocated. In 1995, it had been $665 million. Planned Parenthood International gets 73% of its revenue from the US government (CL, 1/97).

*Planned Parenthood of Minnesota and South Dakota ran an ad in its area that announced in bold letters, "Babies are loud, smelly, and expensive. Unless you want one" (LA, 3/97).

*Apparently, abortion ideology is interfering with the correct teaching of human embryology in schools and colleges. At an exhibit of human embryology by an anti-abortion group, a teenage youth came up and told one of the exhibitors that the exhibits were all a lie, because human embryos looked nothing like what the display was showing. Apparently, the young man's mind had been

filled with pro-abortion propaganda that the pre-born human was not human, but was a cancerous or gangrenous growth, uterine tissue, a gobbet of meat, garbage, etc.

*In Canada and the US, abortion protestors have sometimes been forbidden to display "offensive signs" (i.e., of aborted babies) in public or arrested for doing so.

*Columnist John Leo (USN&WR, 4 May 98) said that convicting abortion protestors under the 1970 US Racketeer Influenced and Corrupt Organizations Act (designed to combat organized crime) was an outrage, and set a precedent for oppressing any protest movement.

*A TV ad campaign against abortion, entitled "Life: What a Beautiful Choice," elicited death threats against the sponsor of the ads (CS, 7 Oct. 93).

*No sooner had South Africa been liberated than it embraced abortion on demand! Among many other things, its health minister said that any physicians unwilling to perform abortion should not enter the practice of obstetrics or gynecology (NC Register, 16/11/97). Things will go very ill with South Africa!

*In 10/96, HBO TV ran three pro-abortion propaganda dramas under the title of "If These Walls Could Talk." The dramas are set in 1952, 1974 and 1996, and even media critics commented that they were primarily polemics.

*Newsweek (1 Dec. 97, p. 44) likened recent terrorist killings by Islamic extremists, and the Aum Kyo cult attempts at terrorist gassing of the public in Japan, to the bombing of abortion clinics in Atlanta (in which nobody had died). If this is not propaganda, we do not understand the meaning of the term.

*One phrasing used in a feminist pro-abortion book is that a fetus reroutes a woman's circulatory system, and enlarges and displaces internal organs, and that a woman therefore has a right to defend herself against such an assault on her body (NRLN, 12 Aug. 97).

*Mouth (11/97) commented that groups such as The Arc (formerly the National Association for Retarded Citizens) and the National Down Syndrome Congress "are quick to spot even the most subtle forms of discrimination," such as potentially unequal access to dental treatment, but have refused to take a position on economic and eugenic warfare against the unborn (including by abortion) who have been identified as having an impairment such as Down's syndrome, and likened these positions to the NAACP refusing to come out against slavery. Of course, the reason is that the majority of members of The Arc are in favor of abortion and of government funding for the abortion of children who would be retarded.

*At least in the San Francisco area, 90% of Jews approved the proposition that "women should be able to have abortions without restriction" (FT, 5/96). It has been speculated that this has much to do with Jews feeling more secure in a liberal society, because they associate the political right (which is less supportive of abortion) with the threat of anti-Jewish sentiments.

*It has been said that perhaps the largest assemblage of powerful pro-abortion advocates ever to gather in a Catholic church occurred at the funeral mass of US Supreme Court Justice William Brennan who died in 1997. For several decades, he had been the leading pro-abortion justice on the Supreme Court.

*A nun who is a supporter of the pro-abortion group Catholics for a Free Choice was elected president of the Catholic Theological Society of America (FT, 4/98).

*Rather ironically and oxymoronically, abortion is commonly listed as a "reproductive service" and "health service." In fact, on her Latin American tour in 10/97, Hillary Clinton used the term "reproductive health services" as a code phrase--well understood by her audiences--for abortion (SHJ, 17/10/97).

*People in the contraception and abortion business claim that more than half of all US pregnancies in women age 20 and older are "unwanted," that 60% of pregnancies in older women get aborted, and that one-third of public welfare to dependent children supports children from "unwanted pregnancies" (APA Monitor, 9/97).

*Even the pro-abortion Alan Guttmacher Institute has shown in a survey that women who have abortions rarely have them for the reasons that abortion advocates often cite as a rationale for pro-abortion laws. The percentages that follow do not add up because they overlap, with women commonly citing multiple reasons. Thus, 76% were concerned with having to change their lifestyle, and 68% were concerned about the cost of having a baby. These two reasons amount largely to materialistic and hedonistic rationales. In 51% of cases, the woman was in a bad relationship and was afraid that she would face single motherhood. In 31% of the cases, the woman said she was not ready for the responsibility of parenthood, or was ashamed to reveal that she had had sex or was pregnant. The women's health figured in only 7%, and rape or incest in only 1% (FT, 12/96).

*A new feminist and pro-abortion phrasing is that a woman "gets made pregnant by a fetus," rather than by having sex (NRLN, 12 Aug. 97).

*US government statistics often report maternal deaths from abortion as being deaths from the complications of pregnancy (BRMM, 7/96).

*In medical emergency services, there is a phenomenon called an "oops abortion," which means that the baby survived the abortion. In such instances, pro-abortion people get terribly confused whether to refer to the child as a fetus or a baby, and may stammer incoherently (LA, 5/98).

*The Syracuse Herald-Journal (30/6/98) claimed in the headline of an editorial(!) that government inaction in approving RU-486 "punishes women."

*In Nevada, a former employee of an abortion clinic staged a robbery at it, during which he shot one of the abortionists. The media interpreted this as "pro-life violence" (Celebrate Life, 9/96).

*An abortion clinic in Indonesia, operating under the guise of a birth control center, had a problem disposing of its aborted babies. It then secretly dug a mass grave in the back yard of a school for mentally handicapped children that happened to be near the abortion clinic which, of course, was not a very good location juxtaposition for the latter to begin with (NC Register, 1/98).

*Bad image! In 6/97, Kentucky Fried Chicken was advertised with the slogan "Freedom of Choice." However, there was no indication that the chickens themselves got any choices. They are in the same position as the aborted babies who had no "choice" either.

*The abortion lobby has always very carefully controlled its idiom, and succeeded spectacularly in forcing its own idiom on the society at large, as by coining the phrases "pro-choice," "a woman's right to control her body" and so on. Around 1995, according to some observers, there have been efforts by the abortion lobby to shift the idiom away from choice and toward rights, specifically "abortion rights." Supposedly, people today are even more concerned about getting their rights than doing something that is merely tolerated by others. After all, rights must be protected with a passion, while "choice" can be treated with indifference. Furthermore, rights language opens the door to governmental coercion. For instance, if I have a right to clean air, my neighbor can be

*Evangelist Billy Graham has approved of abortion for "exceptional cases" like fetal deformity, rape, incest--and overpopulation (LA, 7/97).

*We have encountered claims that a significant proportion of the money raised by Jerry Lewis through his muscular dystrophy telethons goes to fund research to identify affected babies in the womb so that they can be aborted.

*The firm of Hannah Anderson, a maker of expensive children's clothing (sold mostly through mail orders), supports abortion by making its telephone banks available to help out pro-abortion political candidates (LA, 1/97). Until 1992, it also supported homosexual rights; the two of them often go together.

*There are strong links among sexual promiscuity, pornography, exaltation of homosexuality, and endorsement (and even promotion) of abortion.

*According to Culture Wars (2/97), people who seek admission to the US on grounds that they are being persecuted in their native lands for being homosexual are more likely to be admitted than women who seek admission because they are at risk of compulsory sterilization and abortion in their homeland--mostly in China.

*The Playboy Foundation has donated much money to causes having to do with the defense or promotion of abortion, homosexuality and animal rights (FT, 10/96). What a juxtaposition!

*Sarah McLachlan, a pro-abortion pop musician and singer, invented a series of concerts called Lilith Fair. Lilith was a demonic figure in mid-eastern mythology, including in Jewish legends, and the mother of legions of other demons. In Persia and Sumeria, she was feared as a baby-stealer and baby-killer. McLachlan and contemporary feminists have declared her to be a goddess, which she never was. They also interpret her as a female badly treated by an overbearing "patriarch" (an arch boo-boo term for feminists). They also made her the "goddess of rage, alienation, stillbirths, abortions" (a women's encyclopedia), and occasionally the goddess of divorce. Now if only McLachlan could get together with the Playboy Foundation.

*Strangely enough, classical musicians are said to be one of the most reflexively liberal groups in US society, and virtually unanimous in their support of abortion (FT, 8/96). Apparently, this explains why a 1995 composition entitled "Requiem for the Unborn" by Kurt Sprenger had to be performed by a Polish orchestra and chorus. It will probably not be played on secular US radio stations, and probably not be sold in secular music stores (FT, 8/96). No such troubles have beset pieces of music associated with ecology, homosexuality or AIDS (e.g., the so-called AIDS symphony composed in 1990 by John Corigliano).

*At some "gay parades," homosexual men have marched not only naked but even with full erections wearing nothing but condoms, but this is not considered an obscenity requiring the intervention of the law. However, standing in a public place with a picture of an aborted baby may draw upon one the legal charge of displaying an "obscene sign" (LA, 10/96).

*President Clinton and his wife have been among the staunchest imaginable supporters of abortion. We cannot help but wonder whether they have not been both involved in abortions themselves. In fact, one of the women who claimed to have had sex with Clinton also claimed to have aborted his child. Someone said that pro-abortion principles seem to be the only principles that President Clinton seems to have (NRLN, 11 June 96). Indeed, he is so profoundly identified with abortion that almost the entire pro-abortion feminist movement has hardly expressed any public disapproval over his sexual peccadillos. Even feminist Barbara Ehrenreich said (Time, 9 Feb. 98) that the feminists all seemed to have gotten laryngitis. They used to yell "rape" at no more than men's lustful glances. We have to understand that much of the battle over what should be done with

him is a front for the abortion war parties. According to the president of the Syracuse chapter of the National Organization of Women (NOW), "The stakes in the Clinton scandals are high": the rights to abortion, other women's rights, and "rights for which homosexuals have fought" (SHJ, 22/9/98). What is at issue here was actually spelled out with utter explicitness by a former Time newswoman: "I'd be happy to give him oral sex just to thank him for keeping abortion legal" (Newsweek, 20/7/98). The intense efforts to discover and publicize the secret sins of the leaders of Congress in charge of determining the fate of Clinton were certainly the results of a pro-abortion "left-wing conspiracy"--the conterpart to the "right-wing conspiracy" charged by Hillary Clinton with trying to bring the President down.

*On the one hand, the NJ legislature banned partial birth abortions, but on the other hand, the state Medical Society released guidelines on how to do them, and argued that it was improper for "politicians" to restrict them (NY Times, 23/12/97).

*One supposed authority on Down's syndrome, Dr. Bill Cohen of the Down Syndrome Center of Western Pennsylvania, supposedly said that abortion of children with Down's syndrome "is not a right to life issue. This is a choice issue. This is an information issue" (Mouth, 11/97).

*A nursing student had been working part-time for the Planned Parenthood Center in Syracuse, reporting that everyone there was "sympathetic, caring and patient." At that facility, an average of five babies have been killed every working day for many years. Nazi death doctor Mengele was also commonly described as very kindly. Even the twins in whose eyes he injected dye as part of his racial studies reported how kindly he always treated them.

*At least the full-time abortionists in the US are a sleazy bunch, which is at least one reason why other physicians have increasingly distantiated themselves from them. A Milwaukee abortionist had his medical license suspended because he stole drugs that were supposed to be administered to the women on whom he performed abortions, and used them on himself (LA, 5/96).

*A Colorado physician who has bragged of performing tens of thousands of abortions complained that the term "abortionist" is a "demeaning, degrading term that conveys evil and disgrace" (NRLN, 14/11/96).

*Among the many skeletons that were found in the closet of the pro-abortion Dr. Henry Foster after President Clinton had nominated him in Spring of 1995 as surgeon general was that during the 1960s and 1970s, he had performed unnecessary hysterectomies on severely retarded women. He explained this away as having been well within the norms of medical practice at that time, which in the opinion of the TIPS editor is totally untrue. Such things were occasionally done then, but not all that often; and there were people even then--in particular during the 1970s--who were vigorously opposed to this practice. Clinton's nominee after Foster was Dr. David Satcher, who promptly made the lying claim that partial birth abortion was for the health of the mother. There is never an instance where the partial birth procedure is performed for the life or health of the mother.

*Some parties claim that in the US, more women die from complications of pregnancy than the government reports (PFN, 15/9/96; source item from Nancy O'Connor). While we would not be surprised that this is so, many advocates cite this information primarily in order to promote abortions.

*A writer asserted that it was "absurd to pretend that brain disease was just a private matter" (in actuality, referring to schizophrenia), while at the same time, the same kind of people would argue that abortions are private matters (Newsweek, 20/7/97).

*Science (the most widely read scientific periodical) carried an article entitled "Toward Safe and Effective Medical Abortion" (24/7/98). The proper Nazi analogue of this would have been "Toward Safe and Effective Medical Disinfection of Jews."

*There is now a movement in the US to forge a "moderate position" with a "common ground" between pro- and anti-abortion parties. One attempt is to invoke the "just war theory" criteria as justification for "just abortions."

Along these lines, on a May 1998 weekend, a peculiar event with much academic participation was held in Syracuse, NY, namely, a conference to try to find "common ground" between pro-abortion and anti-abortion advocates. One major theme of the conference was "that people of faith can have divergent views about abortion," and that "God...is on no one's side exclusively" (SHJ, 19 May 98). While we do not endorse the hatefulness, or even violence, on either side of the abortion controversy, we find it hard to see how those opposed to abortion could really try to make peace with the other side so long as the other side continues to promote and practice what abortion opponents consider deliberate killing. How would people feel about a conference that tried to promote the idea that there was a common ground to be found about killing Jews?

Abortion: Opposition to It

*In traditional Judaism, abortion was a capital crime, the only exception being if the mother's life was in danger "definitely and without question," which was traditionally interpreted to mean that the baby could not be delivered, even after several days of labor. Judaism has also taught that this principle is universal, and applies not only to Jews (as Kosher law would) but to all of humanity.

*The abortion lobby in the US has come to the conclusion that the anti-abortion forces can not win in the legislatures or the courts, but that they have so intimidated or indoctrinated physicians that fewer and fewer will perform abortions, making abortions more difficult to obtain and thereby contributing to a decline in their numbers. One other reason why physicians have become reluctant to be identified as abortionists is that even the abortion lobby has been aware that abortionists tend to be the losers and wash-outs of medicine. (Some people have called abortion the red-light district of medicine.) After all, most young people go into medicine in order to save lives, not to end them.

*A Catholic hour radio host in Syracuse discovered that Planned Parenthood (PP) had failed to secure the rights to its own name on the Internet, and registered himself as the owner of the "Planned Parenthood" site. We thought that this was perhaps not very coherent, but very funny. When PP found out, it was, of course, enraged, and sued, and the case is now actually before the Supreme Court.

*Apparently, 82% of US pharmacists are balking about filling prescriptions for abortion drugs such as RU-486 (Time, 19/5/97).

*According to an item on the CBS Evening News of 12 August 1997, a young "black" woman was diagnosed with breast cancer early in her pregnancy. Physicians recommended she have an abortion, because treatment of breast cancer via chemotherapy is very harmful for the developing child. But, according to the woman's mother, she reasoned that she probably would not have many years left to her anyway, whereas her child would, so she opted to forego any treatment and carry the child to term. The child was delivered 11 weeks prematurely, but healthy, and the mother died five days later. One doctor said that hardly any of the physicians associated with the case could even imagine someone making such a decision, let alone understood it.

*An article in First Things (4/98) argued that the anti-abortion parties have been adhering to a fundamentally ineffective strategy. They have been trying to convince people that the unborn are human babies, but the article asserts that particularly women--at least nowadays--are vastly more

concerned with what an unwanted pregnancy means to them, rather than with how real, or how human, the unborn child is. The article claims that strategies that deal centrally and primarily with the woman's concern are vastly more likely to dissuade a woman from abortion than arguments about the humanity of the child, or its child identity. While there is evidence that at least some people are deterred from abortion when they discover that real babies are being killed, it does make perfect sense to us that modernistic people would be concerned primarily with and for themselves, and that their concern with themselves, and an assertion of their own god-like autonomy and independence, would tend to override all other considerations, and particularly considerations of what some competing god may have designed or ordained.

*Not mentioned in the media is an incident that may have been decisive in convincing some US senators to vote against partial birth abortion in 9/96. While Senator Santorum from Pennsylvania, who had lost a congenitally impaired baby, was passionately emphasizing that an unborn baby is not an appendix or a blob of tissue but a baby, the Senate chamber was suddenly filled with the cry of a baby. As it turned out, a baby was apparently being carried in a hallway by a visitor, and for a few seconds, while the Senate door was open, its cry was heard on the Senate floor. The Senate was hushed in silence for a short moment by the presence of the voice of the ordinarily voiceless in its chambers (NRLN, 23/5/97).

*If people have no compunctions about calling a newborn baby a fetus ex utero, then why should it be any less legitimate to refer to a fetus as an infantis in utero, i.e., a baby in the womb?

Abortion: Incoherent Stances

*Twenty-six of the US states have laws that define the killing of an unborn child as a form of homicide at least during some stages of the pregnancy--unless the child is being aborted (NC Register, 31/5/98).

*Catholic hospitals that do not permit abortions on their premises will nonetheless often collaborate in arranging abortions for their patients elsewhere (NC Register, 6/96)--all in order to get government money.

*Of all the bad mottoes that a Catholic "Center for Ethics and Advocacy in Health Care" (founded in 1995) could have given to itself, it chose "CHOICES."

*It is virtually unbelievable that even the National Catholic Register (9/9/97) carried a headline that presidential hopeful Steve Forbes had adopted a "pro-life stance," even though the article also noted that he supports abortion in cases of rape, incest, and danger to mother's life.

*In 1997, a long-time Catholic peace activist in Syracuse, NY, accepted an award from a pro-abortion civil rights group, with apparently no one seeing any incoherency in this.

*A senior officer of the American Life League recommended in 1996 that people who oppose abortion should buy stock in companies that sell abortifacients so that they can influence corporate policy (CL, 7/96).

*A Christian anti-abortion group rejoiced that its prayers were answered when the owner of a clinic doing abortions died of cancer, and her successor also quickly developed cancer (LA, 4/93).

*The FBI SWAT assassin who shot dead Mrs. Weaver and her baby at Ruby Ridge in 1992 was a fiercely pro-life Catholic who was prepared to resign if he ever had to defend an abortion clinic (Newsweek, 18/9/95).

Abortion: Miscellaneous Facts & Developments

*Abortion on a large scale is practically a world-wide phenomenon now. Since 1960, surgical abortions alone have increased from about 40 million a year to about 55 million. There is no legal protection for the unborn in countries that between them have 66% of the world's population. Population control proponents will be elated to learn that surgical abortions have killed about 1.8 billion babies between 1960-1997, or about a third of the world's population (NC Register, 5/98).

*According to some estimates, only 15% of women in Russia have not had abortions (NC Reporter, 22/9/96).

*In Washington state, pharmacists can dispense drugs to women in order to induce abortion upon oral instructions from a physician without an accompanying prescription (SHA, 21 Dec. 1997, pp. A1, A11)--surely the only circumstance in which such non-recorded dispensing of controlled drugs is permitted, just as abortion is the only medical procedure for which the woman does not have to be informed of all the risks, and the only significant medical procedure on which the government does not keep statistics.

*For reasons not well understood, the rate of abortion in the US has declined since 1980 (NC Register, 14/12/97). Eventually, the number also declined, to about 1.3 million a year as of 1993 (CL, 7/96).

*The good news is that the US is beginning to run out of physicians willing to perform abortions. Alarmed by this, Planned Parenthood has developed an Abortion Training Initiative which, among others, has enrolled a number of pediatricians and family practitioners to learn to perform abortion. In medical school training, pediatricians are taught practically no surgery at all, and family practitioners usually only learned minor surgery, so this is almost like training psychiatrists to perform abortions (Physician Financial Times, 30/9/94; source item from Nancy O'Connor).

*On the one hand, a large proportion of unborn babies with Down's syndrome get aborted, but on the other hand, women have been postponing having children. The latter explains why incidence of Down's syndrome has increased, which in turn explains why despite all of the abortions, one still sees more children with Down's syndrome than one would have guessed considering how high the abortion rates are (Mouth, 11/97).

*The code "86" is reportedly used in the restaurant and hotel business as a communicator that a guest is to be thrown out. Thus, it is somewhat ironic that RU-486 is a drug used to throw a baby out (LA, 1/97).

*An agency in Manchester, England has started to offer early pregnancy abortions that only take 10 minutes and can be completed "during a working woman's lunch break" (NC Register, 20/7/97).

*We continue our litany of different kinds of gruesome abortion procedures that we reviewed in the 4/96 issue by adding yet another one that seems to be particularly common in cases where pre-natal tests have identified the unborn as having anencephaly. The procedure then often used is to induce labor so that a non-viable child will be born (NC Register, 10 Nov. 96).

*Relatively new abortion methods (especially for early abortions) have used the drug methotrexate and another one (either misoprostol or cytotec). Misoprostol is also part of RU-486. Methotrexate is listed in the Physician's Desk Reference as one of the most toxic prescription drugs marketed in the US. There, most drug entries average a half page of text, while methotrexate covers

6 pages, including the advisory that the drug should never be used without the patient being informed of the possibly serious consequences. This latter is particularly ironic insofar as US law has virtually forbidden that abortion dangers be communicated to women (LA, 1/97). In fact, women are rarely told how dangerous this drug is, and that it can damage them permanently (CL, 9/96). Abortion by means of methotrexate and misoprostol has been cute-sified as the "M&M procedure" (e.g., LA, 1/97). Newsweek (11 Sept. 95) claimed that this drug combination assured "safe abortions," constituted a "breakthrough" that would "transform abortion in America." And besides, both drugs were "valuable against cancer and ulcers," and hence would not be "hounded off the market."

*Someone has referred to partial birth abortion as "1/5th abortion and 4/5ths infanticide" (NRLN, 11 June 96).

*Amazingly, the Smithsonian Institution mounted an exhibit under the theme "Better Than Nature: The Pill" which celebrated the "birth control" pill as "a prime example of the use of scientific knowledge to control and improve nature." The exhibit includes a display which gleefully made the point that Catholics are defying their church in embracing contraceptive pills. The exhibit was financed by the American Chemical Society (Celebrate Life, 9/97).

*Robbers in the State of Washington have discovered a sure-fire way of getting away with bank robbery: they first explode a bomb in front of a Planned Parenthood office, wait for the attention of the police to be fully absorbed by this on the assumption that this was an act of "pro-life violence"--and then rob a bank (LA, 9/96).

*Particularly offensive are mothers (or couples) who say they are joyous that their baby is alive--but nevertheless sue for big bucks because they believe they were not given a proper chance to abort it (news item from Ruth Abrahams).

*Several articles that appeared in British newspapers in August 1996 were very explicit in acknowledging that the unborn are live and human, that abortion for any reason whatsoever has become legal and accepted, and that having given its approval to unrestricted abortion, society has entered on a slippery slope from which there is no turning back (source items from Rob Henstock). As one author put it, "Society should draw the line, or slide into the morass where life no longer really matters" (The Guardian, 1 Aug. 96, p. 17). Another writer noted that if only people "were a little more intellectually brutal," they could explicitly state "Abortion is murder, and I am in favour of it," as at least one American commentator has done (The Sunday Times, 11 August 1996, p. 7). These articles and opinion pieces were stimulated by two cases in Britain that received international attention: the abortion of one twin by a woman who claimed she could not afford to have and rear both children, and the destruction of thousands of laboratory-created human embryos that had been kept in cold storage for future implantation. A third article noted the paradox of advances in intra-uterine surgery that can help vulnerable fetuses survive until birth and be born healthy, while at the same time "advances" have been made in destruction of fetuses in the womb. Sometimes, these two types of procedures are going on next door to each other in the same hospital (The Sunday Times, 11 August 1996, p. 7).

*There is now an Internet support group for parents who "interrupted a wanted pregnancy following poor prenatal diagnosis." The participants generally acknowledge that what they killed was their baby, and they feel mournful--but not repentant about it (Mouth, 9/98).

Abortion: The Consequences to the Mothers

*As early as 1969, journalist Barbara Seaman wrote an exposé on the relatively new (birth control) "pill" entitled, The Doctor's Case Against the Pill. Its cover said, "love with the pill can cripple and kill." Seaman was then ostracized and fired. Yet much of what she found has held up.

*To the glee of the local Planned Parenthood, Lourdes Clinic, a Catholic clinic directed by a Catholic nun in the Syracuse diocese, gave an 18-year-old woman an injection of the abortifacient Depo-Provera, upon which she went into a coma (LA, 5/97). We do not recall seeing this covered in the local news.

*Because artificial birth control is the politically correct thing to do, its deleterious effects on women (and others) are kept a quasi-secret. For instance, Progesterone thins the tissue on the vaginal surface, and this is one of the mechanisms through which it works in various so-called contraceptive pills and drugs. However, for that very same reason, the vagina becomes much more vulnerable, as to virus infections. Accordingly, monkeys who have used Norplant implants which contain Progesterone had an almost 8-fold higher incidence of vaginal transmission of HIV, and there is every reason to assume that the same happens in human females (LA, 1/97). Women may also not be told that yeast infections are common in women who use oral "contraceptives," as well as certain other drugs (e.g., steroids). Nor is it widely disseminated that one-third to one-half of women on oral contraceptives get dark blotches on their faces. The occurrence of such a non-specific unintended effect suggests strongly that yet others can occur as well.

*There is a huge deception and denial going on about the fact that studies have very strongly implicated abortions as one cause of women's breast cancer. The New England Journal of Medicine even editorialized that there was overwhelming evidence that there was no relationship.

*There is also massive denial of so-called post-abortion trauma, i.e., women getting depressed over having killed their child. Actually, in all cases where a couple conceived in love, it would be abnormal not to get depressed.

Abortion: The Societal Consequences

In 1994, Mother Teresa said three things about abortion. (a) If people come to believe that mothers may kill their children, then they will also believe that they may kill others. (b) If abortion is accepted as legal in a country, then its people will learn that one may use violence to attain what one wants. And (c), abortion destroys peace and makes people insensible toward the needy. Modernism has been called a "culture of death." It is amazing that the citizens of modernism can see absolutely no connections among their de facto celebration of large-scale killing of unborn children, and outbreaks of irrational rage killings, and of children shooting back. That so much of the violence that is now being visited upon us is perpetrated by our children is not only an act of justice, but of ironic justice at that, and also contains a continued warning to repent of child-killing, or the point will come when repentance will neither be possible nor be able to undo the ongoing violence that is visited back upon society.

Artificial Baby-Making & Related Deathmaking

Artificial baby-making is objectionable for multiple reasons, only one of which is that much of it involves a great deal of abortion or related deathmaking.

*Paul Simon once wrote a song called "50 Ways to Leave Your Lover." An article in the May 1998 issue of Discover: The World of Science identified 13 ways to make a baby (p. 80)--but failed to include in this list the "old-fashioned" way! The entire issue was devoted to "Reinventing Life," with articles on cloning, customizing life forms, organ transplants (in this case, from animals to humans), cell transplants, the human genome project, and what it termed "mechanical reproduction" of humans. In all this 100 pages, there was no analysis of the serious moral questions raised by any of this, let alone of more low-level concerns, such as what might be the untoward genetic, disease, and survival consequences in future years. These latter received only a passing mention.

*There have been proposals to "harvest" eggs from aborted female babies for future use. Accordingly, we could have the ironic outcome of an unwanted aborted baby becoming the mother of thousands of children (Discover, 4/97). By the way, this would be way No. 14.

*According to a recent public opinion poll in the Daily Telegraph, 66% of Britons would use genetic technology to improve their children's eyesight, 50% to reduce alcoholism or aggression in their children, 45% to increase their intelligence, and 19% to improve physical attractiveness of their children (Disability Awareness in Action (UK)), Special Supplement, December 97; source item from Katrina Kurowski).

*It is peculiar that some women who resort to fertility treatments if they do not become pregnant when and as soon as they want to are often also women who try to be very thin because that is a stylish and fashionable appearance. It is well-known that without a certain amount of body fat, a woman is very unlikely to become pregnant, but rather than put on some weight, these women instead go the high-tech artificial baby-making route. The slim editor of Harper's Bazaar underwent 9 "fertility treatments" (Newsweek, 6 April 98).

*Women who seek fertility services are rarely told the risks to themselves, nor that they are expected to have "excess embryos" that they conceive aborted (SHJ, 29/4/98).

*Many parents are also not informed that their embryos may be used for research (Newsweek, 12 June 1995).

*In Britain, 3,300 frozen embryos in 32 fertility clinics were destroyed because they had been abandoned. Some of the parents had been rich foreigners who could no longer be located (Guardian, 1 Aug. 96). Oddly enough, Cardinal Hume of Britain favored the destruction, while liberals likened it to a mass execution (SPS, 2 Aug. 96). We can see that this issue scrambles people's minds.

*So far, there is no evidence that frozen human embryos "go bad" with time (as Time put it, 12 Aug. 96). One embryo in the US had been frozen for 7 years, having been forgotten by its parents. Fortunately, they decided to incubate it when asked "what they wanted to do with it" (AP in SHJ, 17/2/98).

*There are couples who, for religious reasons, would not agree to having an abortion, but who would have no compunctions about pursuing a reproductive technology in which some of their fertilized embryos would be "discarded" (Time, Special Fall 1996 Issue, p. 39).

*In 1984, one could buy a human egg for artificial fertilization for $250. By 1998, the price had risen to $5,000, and even to $10,000 for eggs from women with highly desired characteristics (CW, 5/98).

*In Italy, two artificial fertilized embryos from two different couples were implanted into another woman simultaneously, who carried them for the respective natural parents. Upon birth, the babies were sorted out on the basis of blood tests (NC Register, 11/97).

*Advertisements for surrogate mothers and egg donors can now be found in the "Help Wanted" columns of newspapers (source item from Jo Massarelli). In 8/98, we first learned that there was such a thing as a "gestational carrier." A married couple advertised in the paper that it was looking for one (source clipping from Guy Caruso).

*Some artificial baby-makers are also in it for the money. The business is very profitable (Newsweek, 12 June 95).

*The Charcot-Marie-Tooth (syndrome) Association has joined the deathmaker ranks by funding research on lab-grown human embryos (Mouth, 7/96)

Medical Child-Killing

Medical killing of a child soon after birth is an utterly logical step if one is also willing to kill the child before and during birth.

*Several US senators involved in a Senate debate on the lawfulness of partial birth abortion were very clear that they thought that killing a baby within minutes after birth was as much a private matter between the mother and her physician as would be the killing by the partial birth abortion technique a few seconds before the birth (Newsweek, 3 Feb. 97, p. 68).

*According to an article in Pediatrics (1/97), most deaths among hospitalized newborns in the US result from decisions to cease or delimit treatment, and are often based on "quality of life" considerations.

*The 1/97 issue of Pediatrics revealed that pediatricians said that when they advise parents of impaired infants that they should withhold or discontinue treatment (including nourishment), about half the parents go along with the advice (Mouth, 5/97).

*When physicians want to make a baby dead, they may well interpret the administration of milk to the baby as a "treatment" (Mouth, 5/97).

*At the U. of Calif. Medical Center, a physician "euthanized" a 9-year-old handicapped girl with a lethal injection, in response to the mother's request after the girl did not die subsequent to the withdrawal of life supports--also on the mother's request. Amazingly, not only did the doctor get censured, but so did the nurses who blew the whistle (IAETF, 3/95).

*The CBS "60 Minutes" TV program has consistently been propagandizing for various forms of deathmaking. In a 12/4/98 episode, Leslie Stahl, one of the stars of the program, propagandized against life supports for premature babies, some of which were referred to as "micro-preemies." The discourse included phrases such as "saving lives not meant to be," or "condemning babies to a life not meant to be." At one point, Stahl referred to "this...(long pause) person..." Providing treatment for such babies "could mean that they could live to 80." It all reminded us of the Nazi propaganda in support of euthanasia before and during World War II.

*In 1995, we first encountered the phrasing (in connection with medical "euthanasia") that a newborn baby was "painfully deformed."

Private Child-Killing & Child-Junking

*The fact that two unmarried teenagers from privileged families crushed their newborn baby's head and threw the baby in a dumpster in Delaware made remarkably big national news, with both Time and Newsweek (both on 2 Dec. 96) devoting major stories to it. Among the interesting facts were the following: the boy was the only child in his family and his parents were divorced; and there was no evidence that the couple had any remorse. Both the above periodicals expressed outrage at the crime; Time did not hesitate to call the two "monsters" and "evil"; and both denied any connection between the abortion culture and the legitimacy of partial birth abortion on the one hand, and a desensitization of people toward infanticide on the other. In fact, it is hard to believe that Time wondered, "Why didn't they contact a confidential abortion clinic?" In other words, killing a baby seconds after birth was an unspeakable crime, but killing it seconds before, and during, birth is perfectly alright--and we are to believe that there are no connections among these

sorts of killings, and that people will certainly not become desensitized by the latter towards the other!! Another thought here is that if only a physician had done the killing, it might or would have been alright, but for the two teenagers to do it themselves was unconscionable. The teens hired a forensic pathologist who testified on behalf of O. J. Simpson at his murder trial, which is also not good news.

*While we probably have commented on this before, it is becoming ever more apparent that when people (mostly mothers) commit infanticide these days, especially of their newborns, they almost invariably put the corpse into some kind of garbage disposal, such as a trash can, a dumpster, etc. (e.g., Newsweek, 7 July 1997). We believe that this is a relatively modern phenomenon insofar as never before in history (a) have we had the kind of garbage disposal means that we do now, and (b) have unborn children been as persistently interpreted as trash.

*Reports on various kinds of child killings are very inconsistent. According to some sources, 6,000 babies die each year in the US from "shaken baby syndrome." Babies reportedly are more likely to be shaken by inexperienced young (often unwed) mothers (SHJ, 30/5/98).

*According to some estimates, over 4,000 children a year in the US are beaten, stabbed, burned, raped and tortured to death in the US as of 1997 (Casa Cry, 1/97).

*Leave or get babies at Wal-Mart. A Wal-Mart customer in Oklahoma found a newborn baby girl on a shelf in the infants' department (SPS, 13/6/96).

*Family instability contributes hugely to child deathmaking, and does so in multiple ways. One of these is that the risk to the life of a young child increases as much as 100-fold (not merely 100%) when a woman with such a child initiates some kind of liaison with a man who is not the father of the child. In evolutionary terms, a man gains nothing by caring for a stepchild. Of course, socio-biologists have long sketched the dynamics of such situations in all sorts of animal species. The phenomenon in humans has long been denied by many social scientists because they did not want to give the impression that divorce and family collapse were a bad thing. Even if a new man does not enter the picture, a child in a one-parent family (which usually means a single-mother family) is still vastly more at risk--as much as 70 times above baseline. Our files contain many reports of the above type of child-junking by the new man in a mother's life.

*One anthropologist studied bones of more than 5,000 children from hundreds of pre-industrial cultures dating back to 4000 BC, and not once found the scattered bone bruises that are the skeletal signs of the "battered child syndrome" that would now be found in about 5% of children who die between ages 1 to 4 (Time Magazine, 28/8/95). He surmised that unwanted babies were probably killed at birth, but not brutalized thereafter.

*A woman in Montreal held her 6-year-old autistic son under water until he drowned. The story was that she was depressed because she was not getting the support that she needed for her son, and had planned to commit suicide after killing him, but then faltered in her resolve. The Quebec Autism Society called her lawyer regularly to convey their messages of support to her. After pleading guilty to manslaughter, she was given a sentence of 23 months in prison--which was suspended. We might recall that Susan Smith, who killed 2 of her children, got a life sentence, the difference being that her children were not autistic (various 1997 news reports from Guy Caruso).

*When a Maryland woman murdered her baby because it was crying too loud, she got a suspended sentence and regained custody of her other two-year-old child. However, when shortly thereafter, she committed credit card fraud, she was imprisoned, because that was considered to be a serious offense (CW, 2/98).

*While it is true that the vast majority of child abductions in the US are by one of the parents of an estranged couple, an abducted child nevertheless often suffers serious mental or physical harm. Different studies have found everywhere between 8-24% of physical harm or physical abuse, including sexual abuse and death (Time, 11/5/98).

*A Carnegie Foundation panel said that adolescents are "experiencing more freedom, autonomy and choice than ever at a time when they still need nurturing, protection and guidance." It also said that they are very much at risk of "damaging their life chances" because of inadequate education, drug and alcohol abuse, and pregnancy. It said that much of this has to do with both parents not being present to the children, usually because of jobs. They called the situation "a time bomb set in youth" (AP in SHJ, 14/10/95).

*We reported that it now turns out that since the mid-1960s, "crib death," fancified as "sudden infant death syndrome" (SIDS), has been to a very large extent a PPP (post-primary production) human service system invention, and that a large proportion of babies and infants said to have died of SIDS had actually been murdered--usually by a parent. Some parents had murdered all, or nearly all, of their children under the cover of a SIDS diagnosis. A medical professor in Syracuse (Dr. Alfred Steinschneider) had made a virtual career of the SIDS diagnosis, and his work was described as a "stunning breakthrough" (SHA, 5/5/96). He also formed a company to make baby monitors. By 1995, it employed 2,000 workers. Hundreds of thousands of parents attached wires to their babies to sound an alarm if apnea should set in. Entire SIDS centers sprang up, and Steinschneider became president of the American SIDS Institute. Among other things, it was taught that SIDS had a genetic component--because it ran in families (e.g., SHJ, 9/9/97)!

The SIDS episode is a typical case of "pathological science" (like "facilitated communication") in that its "discoverer" sidestepped critical peer review (SHJ, 6 May 96). As one recent book title put it, The Death of Innocents: A True Story of Murder, Medicine and High-Stakes Science. Physicians, nurses and forensic pathologists who raised concerns were ignored, as were warnings by public prosecutors (e.g, SHJ, 6 Oct. 97, 9/9/97).

In Central New York, a woman was discovered to have murdered five of her young children--none older than 27 months--in a six-year period, but not the child that she had adopted afterwards (AP in SHJ, 21/4/95). Initially, it had been thought that all of her children had died of SIDS. In fact, the death of the five infants had been featured prominently in one of the pioneering professional articles by Steinschneider on the syndrome in 1972. One commentator on the trial said, "There have been a lot of killers who have gone unpunished because of Steinschneider" (SHJ, 22/4/95).

Now, a son-of-SIDS theory has it that many cases of SIDS are the product of the Munchhausen-by-proxy syndrome, i.e., "sympathy junky" mothers who kill because of the attention and sympathy that they get in consequence. One medical examiner said that these kinds of women "usually keep killing until they are caught or run out of children" (Time, 1 April 94).

*The very common demonization of children in the media (commented on in our December issues) is a way of disposing people toward child-junking.

*Each year, about 10% of teenage children who are turned out of Russian orphanages because they have come of age commit suicide. Furthermore, because of the breakdown of families in Russian society, there were 17,000 attempted murders of children in 1997 (Guardian, 16/7/98).

Progeny-Junking by Multiple Parties

*In many Third World countries, and especially in Asia, there is virtual warfare against female offspring. To begin with, there is a search-and-destroy campaign by means of ultrasound machines. Unfortunately, these machines are now relatively cheap and easily portable. One may find them in locales where otherwise, even the most basic hygiene and medical conditions are lacking. In India, a prenatal ultrasound test costs $40, and there are about 6 million abortions, and 999 out of 1,000 are of females! In addition, if females do get born, they are often made dead soon.

In India, if a baby turns out to be an unwanted female, midwives will often snap its spine by twisting its upper body. Sometimes, newborns are buried alive, or are poisoned by having tobacco leaves stuffed down their throats. (Tobacco companies, take note: another use for tobacco!) In Chinese orphanages, babies are left starved and untended in their own filth. Female children may be neglected in their own homes in various countries, contributing to high death rates. Wives who do not produce sons may be abandoned. In India, all the above phenomena are found across all castes and classes. Note also here the corruption of medical science!

Killing of adult women (covered later) further contributes to a disproportionate sex ratio. According to the CBS TV program "60 Minutes" (24/1/93), there are about 22 million fewer females than males in India. We have warned before that societies that develop disproportionately toward male demographics will undergo tremendous upheavals, as eventually, there will not be enough wives for the men. The potentially good news is that in such societies, women may become highly valued, as they once were in the Wild West of the US. Revenge for all the child-junking is well on its way, with unmarried men in some Chinese provinces already outnumbering unmarried women 10 to 1 (Time, Fall 90). In Asia overall, there was already a shortfall of about 10 million females in the early 1990s (SHA, 27/8/95), setting in motion a trend toward stealing and abduction of girls and wives, and the buying and selling of young women. Not long in the future, wifeless men can be expected to become a very de-stabilizing force within these societies (SHA, 27/8/95). What all this also underlines is that abortion and infanticide tend to be closely linked.

*Because so many people are apt to be opposed to infanticide, it has been suggested to eliminate that word and replace it with neonaticide and filicide, because then more people would be apt to agree to neonaticide, or even filicide, since these would have much less meaning to them than "infanticide" (FT, 1/98). Interestingly, the ethicists are now calling upon sociobiology to justify neonaticide.

*Child protection people were called in several times in a Florida case where parents were abusing their newborn infant. After the mother threw the six-month old baby against the wall and the child was left profoundly brain-injured, he was taken away from the parents and a jury ordered the state's child protection agency to pay the child $14.5 million, which hopefully got the attention of such agencies around the country (AP in SHJ, 16/9/93).

Suicide & Its Promotion

There is so much (intentionally planted) confusion among suicide, assisted suicide, induced or hastened death, and direct killing that it is not always clear how to categorize an item. We will try to include only voluntarily self-inflicted deaths here, and cover the confused categories later.

Here is a classical deathmaking slippery slope. First, one legalizes and otherwise legitimizes suicide. Then one promotes suicide. Then one legitimizes so-called suicide assistance. And finally, one kills, or promotes the killing of, people whose lives are deemed futile or unbearable, or who are merely inconvenient.

*In the Hebrew Bible, suicide was a rare phenomenon, with only 6 recorded cases, and in the biblical books added by Christians, there is only one recorded case, namely that of the person who committed the biggest sin since the Fall by betraying Christ, Judas Iscariot, showing just how reprehensible suicide was perceived to be. According to some authorities, suicide only made in-roads into Jewish culture with the advent of Graeco-Roman cultural elements.

*Nationwide, the largest increases in suicide in the US have been among people aged 80-84 (Life at Risk, 2/96).

*Twice as many police officers in the US commit suicide as die in the line of duty. Police jobs are becoming almost undo-able.

*Among youths, suicide is a copy-cat act. Once a pupil commits suicide, several other children in the same school may follow suit (e.g., Time, 22/7/96).

*Some people believe that some of the media are conveying to children the idea that they would be better off dead. As an example, the film "Casper" is cited, based on the long-running cartoon series of "Casper the Friendly Ghost." In the film, Casper is the spirit of a dead child who has a psychotherapist who helps him recover memories of his life and early death. When Casper is asked what it was like to die, he says it was "like being born, only backwards" (Time, 12 June 95). Particularly if children lead an unhappy life, such interpretations may indeed give them the idea that they would be better off if they commit suicide. In fact, the suicide rate by children age 10-14 has more than doubled since 1980, especially among "black" youths. This is a group very susceptible to pro-suicide propaganda.

*Here is a striking example of hysterical teen crazes converging with the contemporary suicide culture. In a Connecticut community, 15 teenage girls who were doing well in school and sports made a suicide pact which somebody described as being "for the shallowest of reasons." Within a 3-week period, 8 of them actually tried to commit suicide (AP in SHJ, 24/6/95).

*A syndicated book review column characterized the suicide manual Final Exit by Derek Humphry as "written in simple, accessible prose with a kindly, loving tone" (SHJ, 6 Sept. 91).

*People who want to kill themselves can now get very graphic instructions from the Internet. Progress has struck once again (Communiqué, 7 April 95).

*A customized plastic over-the-head bag for "self-deliverance" is being developed by the Right To Die Society of Canada (Communiqué, 19/5/95). Maybe one day, there will be parties handing out boxcar loads full of these bags, much as a few years ago they handed out condoms.

*What one will hardly learn from the media these days is that more and more people who commit suicide for reasons other than being sick or "dying" have begun to use the methods recommended by suicide guru Derek Humphry in his book, Final Exit. This included the Heaven's Gate cult group in 1997. Such suicides are now further facilitated by Humphry's organization, the Euthanasia Research and Guidance Organization, having a computer line called "DeathNet," that teaches the Humphry suicide method.

*A woman who directs a suicide crisis line in Seattle considers suicide a "choice"--just another way of handling special situations, "like biting your fingernails or eating a large bag of chips" (CHN, No. 9, 1995).

*In John Wayne's last film, "The Shootist," suicide was already being promoted when a kindly physician suggested to the cancer-ridden hero that he should commit suicide rather than die from cancer.

*A nationwide US study of dying patients found that those in pain were no more likely to consider committing suicide than those without it, but that suicide thoughts were more likely among those who require daily personal help, such as might be provided by home care, but which is often not available. US government regulations effective Summer 1998 are further reducing sick and dying people's access to home care (Life At Risk, 5/98).

*A learned treatise on people who commit suicide by throwing themselves in front of locomotives informs us that people who commit suicide in this fashion are not uttering a cry for help but have made a firm determination to die, yet obviously without consideration for other people such as the locomotive drivers who are severely traumatized by such events. In Germany alone, about

1,000 people a year commit suicide in this fashion, triggering an epidemic of mental problems among locomotive drivers.

*Many nursing home residents actually do bring about their own deaths by refusing to eat or take their medications, but these deaths are reported as due to pneumonia or heart failure (which is pursuant to starvation or slacking off one's medication), rather than as suicides--not to mention as systemic and long-term deathmakings (Parade, 28/9/97).

*Jump! Jump! Jump! The 1,000th person jumped to his death off the Golden Gate Bridge in 1995. One San Francisco radio station had offered a prize for the 1,000th jump, giving daily updates as the tally got closer (SHJ, 1 July 95).

*Some medical deathmakers have begun to recommend to patients, and even to their own family members, that the way to die when they want to is to simply refuse all food and fluid. In fact, this strategy has received a new acronym, PRHN, standing for "Patient Refusal of Hydration and Nutrition," which is promoted as a very convenient "alternative to physician-assisted suicide or voluntary active euthanasia" (IAETF Update, 9&10/94). By the way, which is the alternative to which?

*According to Communiqué (6 Oct. 95), the suicide culture is spreading particularly rapidly in the upper and upper-middle classes in the US. However, two things are also becoming clearer: something often goes wrong that makes a suicide into something other than the neat, painless, and aesthetic event that it is interpreted to be; and a lot of the so-called suicides are just plain simple killings, a very common method being the one recommended by the suicide organizations, namely suffocating somebody by putting a plastic bag over their head and--if need be--holding them down if they struggle.

*Americans kill each other while Canadians kill themselves, having a suicide rate 57% higher than the US rate (CHN, No. 9, 1995).

*Guns aren't lawful;
Nooses give;
Gas smells awful;
You might as well live—Dorothy Parker

"Euthanasia" Via Assisted Suicide

Let it be perfectly clear that "assisted suicide" should refer to intentionally making it possible, or easier, for someone to commit suicide. It should not refer to killing a person because that person asks for it, or because one assumes that the person wants to be dead. If one actually kills a person, then one is not assisting in a suicide, but performing homicide--most likely murder since the act is premeditated. To call such homicides "suicide" or "suicide assistance" is an act of detoxifying deception.

If one assists in a person's suicide (in the above sense), one is at least as culpable of that person's death as that person him/herself, and often even more so, because one may have had a much clearer mind about it than the victim him/herself.

"Voluntary euthanasia" used to mean that one kills someone who wants to be put out of his/her suffering. It should not refer to assisted suicide in the above sense, but nowadays, one cannot assume to know what this term is supposed to mean unless one can get it all explicated.

However, we are fairly certain that the "assisted suicide" referred to by some of the items below refers to more than suicide assistance.

*Sometimes, the reason why there is no law against something is that no one thought the act at issue could ever occur. This is why more and more laws are being passed against things. For instance, who would have thought that one needed a law against blowing up court houses? As long

as suicide was outlawed, one did not need a law prohibiting suicide assistance, but ever since suicide became legal, this meant that there was no law prohibiting suicide assistance, as 29 US states discovered in 1994 (SHJ, 17/5/94).

*We were struck that on several different occasions, media headlines asked whether suicide should be legalized, when in fact suicide has been legal a long time, while the articles under these headlines actually dealt with the legalization of physician-assisted suicide, a form of "euthanasia" (e.g., Monitor, 2/97). Apparently, by posing the question as if it were whether suicide itself should be legal, the media are attempting to garner support for assisted suicide.

*There is bad news and worse news. The bad news is that it is being predicted that abortion will become a less prominent issue of discussion in the years ahead. The worse news is that it will be replaced by controversy about so-called suicide assistance. One prediction is that after a few people like Kevorkian have been brought to trial and acquitted, there will be little or no further prosecution of such cases, and assisted suicide will become de facto legalized even in the absence of permissive legislation, because prosecutors will not want to waste their time pressing cases that have a history of precedence of acquittal and few prospects of future conviction. In essence, this is what happened in the Netherlands decades ago, leading to mass "euthanasia" there.

*The former president of the German Euthanasia Society was called to court for selling cyanide capsules to more than 130 people who said that they wanted to die, charging them staggering prices between $2,000-6,000 per capsule. Unfortunately, there was no longer a law in Germany against either suicide assistance, or making a killing helping others to kill themselves. The good news is that about 15% of the members of the organization left it when the scandal became public (AW, 2 April 94).

*The US Circuit Court of Appeals (a high-level federal court) in San Francisco reasoned in 1/96: "There is a constitutionally protected liberty interest in determining the time and manner of one's own death. If broad general state policies can be used to deprive a terminally ill individual of the right to make that choice, it is hard to envision where the exercise of arbitrary and intrusive power by the state can be halted." Another Appeals Court in New York ruled in 3/96 that refusing to accept treatments, or deciding to discontinue treatment, is "nothing more nor less than assisted suicide," and therefore, under the Equal Protection clause of the Constitution, it would be legal for physicians to make lethal drugs available to patients who request them. What this means is that the term "suicide" has now been applied to the full range of decisions, from not to accept a head transplant to homicide, totally gutting the traditional meaning of what suicide is, particularly since termination of treatment can also be decided upon by a surrogate. It is amazing that the court system in the US can find in the US Constitution a "right" to physician-assisted suicide. More specifically, the court declared that there was a "liberty interest in determining the time and manner of one's death." The court admitted that the state had a legitimate interest in preventing suicides in general, but not suicide among the "incurably ill" who cannot be "restored to a state of physical and mental well-being." Furthermore, and rather deceptively, the ruling appears to allow for surrogacy decision-making on behalf of people who never asked for death. Amusingly, the court brushed aside the objection of the American Medical Association that helping to put people to death would undermine the ethical integrity of physicians by pointing to the prevailing abortion practice as evidence that "most doctors can readily adapt to a changing legal climate" (Life At Risk, 3/96). Thus, once again, abortion has been the wedge for other forms of deathmaking, notwithstanding the fact that all the pro-death people habitually deny that there is such a thing as a slippery slope of deathmaking. The decision will now go before the US Supreme Court, with unforeseeable results.

*Now that physician-assisted suicide has been declared legal by two US federal appeals courts, doctors are coming out of the woodwork and admitting that they have been practicing this form of "euthanasia" all along. In one survey, 7% said they had done it. A Dr. Benjamin from NY City admitted he had done it for 25 years (Time, 15/4/96).

*When the US Supreme Court considered the constitutionality of assisted suicide, organizations that submitted briefs in support thereof included not only the "usual suspects" of civil liberties and deathmaking organizations, but also a homosexual men's group, the Center for Reproductive Law and Policy, the National Women's Health Network--and the American Counselling Association (Life at Risk, 12/96).

*The AIDS lobby is in quite a quandary. On the one hand, it is very much aware that people with AIDS are at a high risk of being made dead in the medical system. On the other hand, it is people with AIDS who have been the plaintiffs in recent suits seeking legal legitimization for "assisted suicide," namely in key cases in Florida and California (IAETF Update, 1/97).

*About 75% of Australians are in favor of "assisted suicide" (Australian, 9 July 96). However, no one may know what exactly they mean by that.

*According to a poll reported by ABC-TV "World News Tonight" on 12 May 1996, the shift of public opinion in support of "assisted suicide" has been tremendous. In 1973, only 43% of Americans favored it, and 50% were opposed. In 1996, 75% of Americans were in favor, and only 23% were opposed.

*A nationwide US poll on attitudes toward "euthanasia" found that young people support "assisted suicide" almost 2 to 1, while older people oppose it by almost the same ratio. Mainline Protestants supported it much more strongly than Catholics or Baptists. When denomination is ignored, but only church attendance is taken into account, then frequent attenders are overwhelmingly opposed while infrequent attenders overwhelming support it. People who know more about physician-assisted suicide are less likely to support it than those who know little about the arguments and facts about it (Life at Risk, 6/95).

*An electronic town meeting in the Canadian province of Alberta, which involved information transmittal and a TV debate, resulted in a vote of 70% in favor of doctor-assisted suicide. In consequence, one of the political parties adopted this as one of its positions (The Economist, 17/9/93; source item from John O'Brien). Also, one of the major Canadian political parties, the Liberal Party, voted overwhelmingly in 1996 in favor of allowing "euthanasia" in the form of doctor-assisted suicide (CLC News, 11/96).

*A classical conflict of interest situation has been revealed by surveys which showed that most frail elderly people in the US oppose physician-assisted suicide, while the majority of their relatives favor it (IAETF Update, 10/96).

*The Economist (17/9/94), a prominent British periodical, has come out in an editorial in support of physician-assisted suicide (source item from John O'Brien). Its argument is very simple and straightforward: "Put the rights of the individual first."

*In one of her advice columns (SPS, 1 May 96), Abigail Van Buren powerfully promoted the legalization of suicide assistance, and glorified the work of the Hemlock Society as an issue of "patient rights" and "dying with dignity," with the latter phrase in the headline of her column.

*Dr. Timothy Quill, who has become one of the most visible deathmaking advocates in the US, has insisted that physician-assisted suicide should only be allowed in the context of hospice care (Family Practice News, 5/97; source item from Dr. Nancy O'Connor). He himself has actually "euthanized" patients, which is why he is now famous.

*For some reason, the state of Oregon has one of the lowest percentages of church-goers in the US, and a long history of anti-Catholic sentiment. This is believed to have played a big role in Oregon becoming the first jurisdiction in the world to legalize assisted suicide by a popular

referendum in 11/94. Another reason was that the medical profession took a neutral or at least passive stance, even though they would be the ones who would have to carry out the popular mandate (Life At Risk, 11/94). With victory in sight in Oregon (see below), the Hemlock Society made an all-out effort to get "assisted suicide" legalized there, including spending $250,000 on TV advertising alone. How successful such propaganda can be was underlined by the fact that the unassisted suicide rate in the state increased greatly, particularly among the impressionable 15-24 year age group (Life At Risk, 2/96). The Oregon law allows physicians to prescribe lethal drugs, but does not permit them to administer such directly. This option was to be made available only to people with an incurable and irreversible terminal disease that would ordinarily cause death within six months--but the law made no exception for such diseases that would not bring about death within 6 months if only they were treated. Many cases of cancer would fall into this category, as well as AIDS.

By voting in favor of a form of "euthanasia," Oregon became the first legal jurisdiction in the world to do so. It is unfortunate that the title of the law was the "Death With Dignity Act." There was nothing in the new law that would prevent the setting up of suicide clinics.

It is amazing that in 1997, the American Federation of Teachers, Educators and Health Care Professionals in Oregon came out in support of the "euthanasia" law. Less amazing is that the Oregon Democratic Party did so as well (Life at Risk, 10/97).

No sooner had the Oregon assisted suicide referendum been passed the first time than the Hemlock Society promptly announced that a lawsuit would soon be filed that would enable the interpretation of the law to be much more liberal than it had been interpreted to be during the campaign (NRLN, 18/11/94).

After being endlessly bombarded with searching analysis and documentation of all the things that are wrong with their assisted suicide "euthanasia" law, the voters of Oregon declared unequivocally in 11/97, and by a yet larger margin (60:40) than before, that they are indeed in favor of death, and that there is simply no mistake about it. For years, "pro-life" people had been arguing that if the citizens of Oregon only understood what the law meant, they would not have passed it, and would indeed repeal it. We appeal to all "euthanasia" opponents to cease pretending that the Oregon vote was anything other than what it is: an enthusiastic endorsement of death. However, anti-"euthanasia" advocates simply will not read the signs of the times, and are planning to challenge the plebiscite in the courts yet once again.

Only weeks after Oregon voters approved "physician-assisted death" the second time, Oregon HMOs on the one hand eliminated coverage for certain services that a life-endangered person might need, and on the other hand announced that they would cover the cost of "treatment" that would end a patient's life (LA, 9/97). Also, some hospice services in Oregon have decided to provide at least partial cooperation with assisted suicide (Life at Risk, 3/98).

Oregon voters overwhelmingly approved their assisted suicide law the second time around in part because they were told that the assisted suicides would be conducted only within the confines of hospice and similar services, and would be very closely safeguarded and watched by the state, with rigorous guidelines enforced to prevent abuse. However, openness and transparency were the first casualties of the new law, underscoring the old wisdom that violence and deception always go together. Among the many deceptions that are now being practiced, the death certificates will not list suicide or assisted suicide as a cause of death, and nothing about the implementation of the law is being revealed to the public. Only physicians long involved with a person were supposed to administer the suicide assistance, but in several cases where the long-term physicians refused to participate, a physician stranger was quickly recruited who was willing to preside over the "euthanasia" and prescribe the poisons. Some such physicians are now being called rubber-stamp death doctors.

Right off, the assisted suicides exceeded the law's limits. At least one of the suicides was not at all suffering from a terminal illness but was merely depressed (NRLN, 9 June 98). Once more we quote our Swiss grandmother: "stupid calves go out and fetch their own butchers."

We had predicted this decisive pro-death breakthrough for some years, and now predict that similar measures will become commonplace elsewhere.

*First, the "euthanasia" people demanded legalization of physician assistance for suicide; but now, they have gone one more step and demanded that taxpayers fund physician-assisted suicide. For instance, a state body in Oregon decided that any of the 340,000 low-income citizens in the state should be provided free of charge with lethal prescription drugs if they want to commit suicide (SHJ, 5 March 98). Of course, taxpayers will save vastly more money by getting rid of these poor people than they will spend on the lethal drugs. It seems rather ironic that poor people who have no right to health care should be defined as having a right to get help killing themselves, and soon to get killed.

*Oregon's assisted suicide law took effect 11/97. Promptly, the state's Medicaid system approved funding for suicide assistance, denied over 150 other services, and most telling of all, in 9/98--without any public or prior warning or announcement--began to deny payment for the drug oxycontin (except to cancer patients) that is crucial for the control of pain in certain serious conditions. As mentioned above, more than anything else, it is pain that drives patients into suicide. So one first makes them hurt beyond human endurance, and then offers to help them kill themselves free of charge (source info. via Joe Osburn).

*Having made dramatic progress, the Hemlock Society (which has promoted both suicide and suicide assistance) changed its image from emphasizing do-it-yourself killing instructions and know-how on suicide to gaining the confidence of physicians. Since physicians were not trained in how to kill people, they now have to turn to Hemlock for instructions, placing Hemlock in a privileged and advantageous position. One of its latest propaganda moves is to interpret medical killing as a "medical procedure"--the same as abortion and capital punishment had come to be interpreted. The phrase "assisted suicide" has been dropped in favor of "physician-aid-in-dying," and Hemlock started to appoint a "national medical director" and established a 12-member medical board that includes physicians, nurses and pharmacists. Hemlock has also been trying to establish alliances with the hospice movement with which it had been on adversarial terms. When Derek Humphry and Hemlock parted ways, John Pridonoff became Hemlock's new executive director in 1992. He is a Congregational clergyman with a doctorate in psychology and 30 years of experience in counseling terminally ill people. Contrary to his predecessor, he has been trying to convince religious people that they are welcome to Hemlock. In order to grow into its own image re-creation, Hemlock may very well change its name yet once again (Oregonian, 20/11/94; source item from Rod Brown). In 1993, Pridonoff wrote, "If God truly has given me a gift of life, then it is mine to do with as I wish." He argues that gifts have no conditions attached to them. Aside from the fact that this is a semantic game ploy, does this mean that if one receives the gift of a gun, one may use it indiscriminately? Also, Humphry himself has strongly asserted his atheism.

On 11 May 1996, Humphry spoke on "Last Rights--When Rights Collide" in Syracuse, NY. Among other things, he talked about people "having the right to sensitive (lethal) information," and that people do not want to be moralized at, but want information on how to take their lives. He appealed to people's ideals of liberty by saying this is "the land of the free, the land of the First Amendment, the land of freedom from other people's religions." He also said that "one way or another, we mean for this to come in, the right to choose how to end your life according to your religion." He boasted that with high technology and the Internet, "you can get around the big boys" (i.e., publishers who don't want to publish it). He singled out Catholic hospitals as having been the biggest opponents of moves by himself, Hemlock, and other "right-to-die" activists to change the laws so as to permit assisted suicide.

Questioned by a participant about what has been happening in the Netherlands and whether this is not what would happen if the laws were liberalized in the US too, he began to squirm and said those people who were killed by physicians in the Netherlands even though they had not requested it "were in such extremis that they in fact were asking" by their very condition. "The Dutch have gone too far too fast, we are not going to permit this to happen, this is not acceptable in America" (meaning anything beyond the very circumscribed kind of voluntary and requested assisted suicide that he claims to be promoting).

He equated conservatism with being reactionary, and used both like they were curse words.

He wants to legalize prostitution too, and thinks the Dutch who have done this are very healthy and reasonable.

A participant asked, "If you restrict the availability of suicide to those with terminal illness," (which he claims the laws he is promoting would do), "then isn't this against the anti-discrimination laws against people with disabilities?" Humphry said, "Yes, there's a lot of legal opinion that this will happen, but it just goes against common sense." In response to another question, he said, "Our animals are fortunate, we have not surrounded them with laws, we have not thrust religion on them, we have not shackled them with these." "It's dignity, it's self-control, it's quality of life that fuels our movement."

*There are already all sorts of books and other publications coming out that walk human service workers (not only physicians) through the "assisted suicide" "decision-making process in a step-by-step manner" (as some put it), embodying of course the standard contemporary intellectual "on the one hand..and on the other" model of "bioethics." One is called "a balanced, compassionate guide." The fact is, we practically run out of quotation marks in talking about this. And don't expect any to be called by their publishers "imbalanced and cruel guides."

*At the International Conference on AIDS in Vancouver in 1996, it was reported that physicians are increasingly willing to help people with AIDS commit suicide. When AIDS specialists in the San Francisco area were surveyed in 1995, 53% said that they had enabled patients to commit suicide by writing them prescriptions for lethal narcotic doses (AP in SPS, 11 July 96; APA Monitor, 4/97).

*The US National Council on Disability is a federally-appointed body that must be composed of stupid calves. It issued a "disability perspective" statement in 3/97 that asseverated the following. "The benefits of permitting physician-assisted suicide are substantial and should not be discounted.... The Council finds, however, that at the present time such considerations are outweighed by other weighty countervailing realities. The benefits of physician-assisted suicide only apply to the small number of people who actually have an imminently terminal condition, are in severe, untreatable pain, wish to commit suicide, and are unable to do so without a doctor's involvement." In other words, suicide assistance is a good thing--but not yet. Perhaps it will conclude that the time is right when the choice is one of suicide or get killed!

*Cancer patients in nursing homes have been found to receive woefully inadequate control of their pain, and those who are very old or members of minority groups very commonly receive no pain medication at all, not even aspirin (multiple medical journals, reported in Time, 29/6/98). This once again underlines that devalued people, and people without vigorous advocacy, are likely to be treated infinitely worse than other people. We should also not be surprised if people callously left in such pain will prefer to die.

*Compassion in Dying is one of several organizations that have come out with a declaration expanding its support for suicide assistance to medical conditions that are not terminal, but that are "progressive and incurable" (Life At Risk, 1/98). Like arthritis?

*Ethical Issues in Suicide is yet another text that under the cover of scholarliness and science comes up with a blatantly religious morality--namely that in the name of individual rights, medical killing (physician-assisted suicide) is moral and should be legal. In turn, a review of this book in Contemporary Psychology (12/95) characterized it as "thought-provoking."

*On a 5/96 news program, suicide arranger Dr. Kevorkian made it clear that his ideology was "absolute autonomy," "pro-choice regardless whether the fetus is a person," and pro-capital punishment. As we keep emphasizing in our teaching, people are never merely in favor of one kind of deathmaking, which is why it is so important to eschew all kinds of deathmaking.

In one trial of Dr. Kevorkian, jurors erupted into tears of sympathy for the alleged suffering of one of the doctor's victims, and acquitted him (AP in SHJ, 22/4/94). A medical expert testified that death by assisted suicide would provide "relief" from suffering that would be "effective and permanent" (AP in SHJ, 27/4/94)--and no one laughed.

*An article in the New Republic of 24/6/96 pointed out that the men whom Dr. Kevorkian helps commit suicide actually tended to be terminally ill, while the many women had much more ambiguous afflictions, and most of them were neither terminally ill nor had severe or constant pain. For instance, one of the people that Dr. Jack Kevorkian "helped die" did not have a terminal illness but had been mentally disordered, and occasionally suicidal for 20 years (Life At Risk, 1/98). Kevorkian has also acquired something like an apprentice (psychiatrist George Reding) who has started helping make people dead on his own (Life At Risk, 1/98). Geoffrey Fieger has been Kevorkian's successful lawyer. In 8/98, Fieger won the primary race to be the Michigan Democratic Party's nominee for the governorship. Richard Thompson has been the prosecuting attorney for Oakland County, Mich., from 1988-1996. He had a conviction rate of about 98%, but he lost his bid for a third term in the 1996 election. Why? Because three times, he attempted to prosecute Dr. Jack Kevorkian, and the voters in his county favor legalized assisted "euthanasia" (NC Register, 5 Jan. 97).

*The North American editor of the British Medical Journal has called Kevorkian "a medical hero," and compared him to other scientific "heroes" such as Copernicus (Mouth, 9/96).

*In the same county in which Dr. Kevorkian has been expediting scores of people to their deaths, a man was indicted for shooting his dog "with impunity." The prosecutor who decided to prosecute the dog-shooting as a felony is the very one who ran for office by vowing not to enforce (e.g., against Dr. Kevorkian) the state's ban on suicide assistance (Mouth, 3/98). The new county prosecutor had barely been installed when he dropped assisted suicide charges against Kevorkian. Ironically, despite the fact that Kevorkian has been at liberty to kill for years, the new prosecutor said that the charges had been "issued in haste" (AP in SHJ, 10 Jan. 97). Yet another case of stupid calves fetching their own butchers.

*It is ironic that death doctor Kevorkian is afraid of flying because "those things can kill you" (Mouth, 9/96).

*People in wheelchairs who are members of Not Dead Yet picketed the home of Dr. Kevorkian in 6/96, calling him Dr. Killvorkian (Mouth, 9/96).

*Oakland County, Michigan, where Dr. Kevorkian has been at work, and Australia where assisted suicide had been legalized in the Northern Territory (and where a physician has helped several people commit suicide by means of a laptop computer that controls the infusion of a lethal drug dose), have been locales where assisted suicide has not only been practiced, but where there has been intensive public debate and intensive media coverage on the issue. It is therefore probably no coincidence that it is in Oakland County and in Australia where there have been epidemics of suicides among youths since 1993. In one Oakland County high school in one school year, there were one successful and 4 attempted suicides, and 15 in the school district overall. In Australia, the youth suicide rate jumped 200% between 1993-1996. It has been speculated that weak, impressionable and/or emotionally wounded teenagers have been indirectly brainwashed by the media coverage into seeking suicide, and into seeing it as a glorious escape from their problems (IAETF Update, 1/97).

*One explanation why the Australian Northern Territory was the first jurisdiction in the world to legalize voluntary "euthanasia" is that according to some people, this piece of land has long attracted individualists fed up with societal restrictions. While Catholics have called the law a sin, the aborigines call it witchcraft (Physician Financial News, 15/9/96; source item from Dr. Nancy O'Connor).

*It should come as no surprise at this time of attempted cost-cutting that several major health insurers have indicated that they would be willing to fund physician-assisted suicide. After all, this would involve no more than the cost of writing a prescription, which could save insurers hundreds of thousands of dollars each time (IAETF Update, 1&2/95).

*Once assisted suicide or voluntary "euthanasia" is defined as a legal right, then it will hardly be possible to deny it to anyone on account of the person's motives. In other words, perfectly healthy people who are mentally disturbed could demand their right to be put to death--as a New Jersey man actually tried to do in 1994 (IAETF Update, 9&10/94).

*Improve your quality of life by dying! The Disability Times in Britain devotes a column in each of its issues to an organization that is "working to improve the quality of life for disabled people." The 1/97 issue gave this column to a voluntary "euthanasia" society that used it to promote the "right" to assisted suicide (Speak Out, 7/97).

*Some years ago, The Arc, founded by parents of retarded people, decided not to take a stand on abortion, and not even against abortion of babies because they are mentally retarded. As of 1998, The Arc also has declared "no position" on assisted suicide for retarded people, in part on the basis of the self-determination and choice crazes which imply that some retarded people might be able to make an informed decision that they want to quit living, and that they want other people to help them end their lives. However, The Arc does encourage its local chapters to explicate any of several competing positions.

*The American Medical Association is talking out of two sides of its mouth in regard to "euthanasia." On the one hand, it says that physicians should honor the wishes of dying patients who want their lives ended, and on the other hand, it says that it is opposed to physicians providing suicide assistance (AP in SHJ, 23/6/97).

*The good news is that as of Spring 97, all but one of the medical societies in the US have ceased to be neutral on physician-assisted suicide, and have begun to take a stance against it. However, the largest-ever survey of cancer specialists in the English-speaking world (in this case covering the US, Canada and Britain) brought both good and bad news. There was less support for physician-assisted suicide for terminally ill patients in pain than a US survey of cancer specialists found in 1994, but it was still 22%. Also, 13% of cancer specialists said that they had performed "euthanasia" or assisted suicide (note how the two keep getting confounded), and 4% had done one or the other within the past year. American cancer specialists specifically reported that they were frustrated in their efforts to recruit palliative care and home care service for people who were dying, and that this apparently inclined many of them toward "euthanasia" or suicide assistance (Life At Risk, 5/98).

*While so many physicians are rushing to embrace "physician-assisted suicide," the New York State Council of Health-System Pharmacists--to its credit--passed a resolution that stated the following (SPS, 10 Aug. 96): "1. To participate in assisted suicide is fundamentally inconsistent with the professional role of the pharmacist. Assisted suicide occurs when someone aids the patient's own death by using one or more euthanizing agents. If a patient induces death him/herself using an euthanizing agent without the assistance from anyone, it is not considered euthanasia, but suicide. 2. The pharmacist should continually educate physicians, nurses, other care providers, the patient and family members about improving quality of life issues."

*To our pleased surprise, the usually pro-death Time (15/4/96) published a guest editorial that contained one of the most forceful condemnations of physician-assisted suicide. The article called the Appeals Court decisions in New York and California that would make the practice legal "unconscionable," and warned of "monstrous God-doctoring." It called the judges "arrogant" and said, "damn them."

*Legislative proposals to allow so-called assisted suicide and other forms of "euthanasia," and judicial legitimization of such things, and actual such laws passed, are coming so fast and furious that we cannot aspire to report them all in TIPS, particularly since superb reportage thereof is available on a very rapid basis from a number of other specialized periodicals. However, as far as we know, TIPS is the only periodical that carries regular deathmaking coverage that is realistic and honest, and does not give false hopes to readers that there will be judicial and legislative victories, that new Supreme Court appointments will stop the deathmaking juggernaut, that a bit of harder work by activists will stop the deathmakers, and that the nation and its broader culture will go anywhere but further downhill and toward Death. This is almost certainly also one of two reasons why hardly any of the many other organizations and publications that are opposed to abortion and/or "euthanasia" ever cover what TIPSreports, or any of the Training Institute's publications related to deathmaking, or ever send anyone to the Training Institute's Sanctity of Life workshops. The second major reason is that our position is in opposition to all deathmaking, by anyone for any purpose or by any means, and virtually all the other parties opposed to abortion or "euthanasia" have some kind of an alliance with death, usually in the form of war, capital punishment and/or self-defense. Apparently, a coherent unity of life position is too convicting, and dissemination of its existence and identity is therefore de facto suppressed. For instance, hardly any of these parties to whom we send review copes of our monographs The New Genocide of Handicapped and Afflicted People, and A Guideline on Protecting the Health and Lives of Patients in Hospitals, Especially If the Person is a Member of a Societally Devalued Class, have announced their existence, much less reviewed them.

The Confusion Among Suicide, Assisted Suicide, Indirect Killing & Direct Killing

As mentioned, the deathmaker dupers intentionally blur the distinctions among suicide, assisted suicide, indirect killing (as by denying/withholding/withdrawing treatments), and direct killings. In turn, many dupees (e.g., much of the public) are now hopelessly confused as to the distinctions. For instance, the phrase "aid-in-dying" actually can refer to at least 3 practices: letting a sick person forego further treatment; providing a supposedly dying person with the means for suicide; and outright killing a supposedly dying person.

*US Court decisions apparently do not use the phrase "physician-assisted suicide," but "the right to die," "the right to hasten death," "the right to refuse treatment," and "the right to determine the time and manner of one's death" (Family Practice, 1 June 96; source item from Dr. N. O'Connor). All these mumbled-jumbled together confuse what is at issue.

*News reports, and even research surveys, often do not distinguish anymore between physicians killing patients outright with lethal injections, and giving them access to lethal drugs to take themselves if they so wish. A good example is the much-cited recent national survey reported in NEJM (23/4/98).

*The Hemlock Society of the US proposed that the term "physician-assisted suicide" be replaced by "physician-assisted death," and that the phrase "death with dignity" should be changed to "death and dignity" (IAETF Update, 12/96).

*A major argument advanced by the deathmaking lobby is that many people want to die because they are in great pain. However, according to research, people who are in pain have been less likely to endorse physician-assisted suicide and "euthanasia" than those who speculated about what they might want when they get into pain. In other words, people in pain are more interested in getting rid of it than in dying. Also, a study in the Netherlands where "euthanasia" is rampant has found that only about 5% of patients there who specifically requested "euthanasia" did so on

grounds of unbearable pain. A much more massive reason cited by one-third of them was fear of dependency on others (Nowak, 1992).

Below follow two subsections of specific kinds of confusions of deathmakings.

Suicide by Proxy: The Step Between Assisted Suicide & Involuntary "Euthanasia"

Once it has been declared legal to help someone to commit suicide, then the next step by the deathmakers, and on the slippery slope, is to kill someone and pretend it was voluntary suicide, and that the victim wanted to be killed. Some people have called this "suicide by proxy."

*Little noticed by many people has been the fact that a US Supreme Court ruling on abortion (1992 Planned Parenthood v. Casey) also constituted a big step forward in the legalization of "euthanasia." Not only did the ruling declare abortion a right that is expressly protected by the 14th amendment to the Constitution (which the courts have interpreted to contain a "right to privacy"), but it also stated that when a patient is mentally incompetent, a court-appointed surrogate may give consent for that person to "assisted suicide." There are so many logical problems with this decision that one does not know where to begin--for example, we thought "assisted suicide" meant a person had to want to kill him or herself, and to ask other people's help in doing so, which is not at all the meaning of "assisted suicide" in this court decision. However, the main point is that the court has in essence declared that the "right" to decide to end one's life is transferrable--i.e., that one person can decide for another--which sets a clear legal precedent for all sorts of deathmakings where one party decides for another that it should not live (source item from John Morris).

*Here is what suicide counseling in a modernistic context can mean. A suicidal man in Sacramento called a suicide prevention center. A counselor took him under his wings--somewhat the way a citizen advocate might, but at a certain point got tired of him, tried to kill him, and almost succeeded. The local prosecutor thought he did this because his protégé apparently "didn't have the guts" to do it himself, and apparently the counselor thought that he should commit suicide or at least be dead, if need be by having someone else do the killing for him (AP in SHJ, 15/6/91).

*Ordinarily, when we plan ahead on killing someone, and then obtain a lethal poison, mix it in a drink and give it to the person to drink who then dies from it, this would be called murder. However, when the person one gives it to is handicapped, then it is called "assisted suicide"--which is what happened in one case in New York where the charge was only second degree manslaughter (LA, 2/96).

*Among physicians, a new deathmaking idiom has arisen, in that some of them are now talking about prescribing or administering lethal doses to patients who, they claim, made an "indirect" request to die (e.g., Life At Risk, 4/98). Obviously, this is a euphemism for physicians deciding that a patient should be dead who has not explicitly expressed such a desire.

*The phrase, "helping someone to die," or even "helping someone to commit suicide," has become a euphemism for murder. A man flew all the way from California to Detroit to "help his cancer-stricken wife commit suicide," but in actuality put a plastic bag over her head and secured it, so that she would suffocate (AP in SHJ, 10 May 1991).

*When people have plastic bags put over their heads and tightened around their necks, they often start to struggle against it even if they previously said that this is what they wanted. A new detoxifier that legitimizes "euthanasia" is to call this struggle a "reflex action" (JAMA, 9 Aug. 95).

*On 18/12/94, the CBS TV program "60 Minutes" brought yet another episode glorifying deathmaking. In 1991, a man killed his father, planning it all down to the last detail, including finding a home for the man's cat, and stopping all the newspapers. Whenever the son put a plastic bag over his father's head, the father started to struggle against it, and so the son finally held his

father's arms down until he had suffocated, and said that he had committed his father to heaven. All this was interpreted as an assisted suicide, and in 11/94, he was let off with two years' probation.

Murder-Suicides Interpreted as Suicides

People--mostly lovers or married couples--sometimes agree to die together, in which case one often kills the other and then commits suicide. This used to be clearly interpreted as a murder-suicide, but now is increasingly and deceptively interpreted as a "suicide pact."

*A debt-ridden family of 5 decided to commit "suicide," but after one of the sons had stabbed the father to death, the rest chickened out. A defense lawyer said that the participants should be charged with "assisted suicide at most" (Newsweek, 2 Sept. 96).

*A New Mexico couple in their 70s made what some people falsely called a "suicide pact," but which was really a murder-suicide pact. The husband suffocated his wife by putting a plastic sack over her head--but then, as happened so often, he chickened out and did not keep his part of the bargain. As has been traditional, and is becoming even more so, he was acquitted by a jury after only 30 minutes of deliberation (IAETF Update, 8/90).

The Promotion or Performance of "Euthanasia" by Physicians or Under Their Direction

*Pernick, M. S. (1996). The Black Stork: Eugenics and the Death of "Defective" Babies in American Medicine and Motion Pictures Since 1945. New York: Oxford University Press. This book documents an episode in American eugenicism which has been almost entirely forgotten. It has to do with an intense controversy about killing, or letting die, impaired newborns that raged in the US from circa 1915 through the 1920s, and which spawned a pro-death propaganda film first entitled "The Black Stork" and later "Are you Fit to Marry?". As late as 1942, this film may still have been shown in smaller theaters and in the hinterland, but only one copy of that film survived. The controversy centered heavily on the physician Harry Haiselden and a baby of the Bollinger family. This book was the fruit of a still-ongoing project of studying over 1,300 films made between 1897 and 1928 for lay audiences concerned with health-related topics. The author relates this material to the present scene. This book is also a gold mine of documentation of eugenics material, and of otherwise little-known incidences of the promotion of "euthanasia" of mentally retarded and other impaired people in the US. Among other things, we learn that comedians George Burns, Jack Benny and Gracie Allen promoted eugenics via a 1936 musical comedy film, "College Holiday."

*Most people have been unaware that there had been somewhat of an underground language about "euthanasia" for a long time. It consisted of references to giving the "black bottle" or the "black needle" to patients. The black bottle contained some kind of drug that would be administered in a lethal fashion to a patient by a nurse or physician, and the black needle referred to a hypodermic injection of a lethal drug. We first learned about the "black needle" from poor "black" people from the rural south, which gave us a moment of recognition when we later ran into the phrase the "black bottle." We would be interested to hear from readers what knowledge they have of these terms.

*At a Vatican conference on mental illness in 11/96, Cardinal Ratzinger revealed that in 1941, when he was 14 years old, a younger cousin of his who had Down's syndrome was transported to an extermination institution and put to death, and the family was told that he had died of pneumonia. From his same Bavarian village, an elderly spinster who was considered to be "mental" was also taken away, as well as three mentally disordered brothers who lived next door to the Ratzinger family. They and others were all reported to have died from pneumonia, but Ratzinger said that everybody knew what had happened to them (NC Register, 15/12/96).

*One of Saudi Arabia's leading theologians has ruled that Islamic law forbids "euthanasia" (LA, 7/97).

*A physician commented in a Toronto newspaper in Fall 1994 that "euthanasia is to the 1990s what birth control was for the 1950s" (source item from Beth French).

*Pro-"euthanasia" sentiment is sweeping the world, to the degree that modernistic values are infiltrating. A newspaper in Bangladesh(!) asked why "euthanasia" should be illegal when abortion was legal. That this is indeed the result of the invasion of modernism is underlined by the fact that there has also been an explosive rise in sexual promiscuity and sexually transmitted diseases in Bangladesh, which in turn have reportedly rendered as many as 15% of couples infertile (Communiqué, 19/5/95).

*The Supreme Court of Colombia approved "euthanasia" for supposedly terminally ill people who have given their consent (IAETF Update, 3/97). One would think that a country controlled by drug interests, riddled with drug crime, with one of the highest murder rates in the world, and threatened by a guerrilla movement had other things to attend to, but then this may be a natural development in a country that has committed or allied itself to death.

*In Japan, a court has laid out for the first time the conditions under which physicians may practice "euthanasia" (IAETF Update, 3/95; Communiqué, 5/5/95). Obviously, what is happening there is similar to what has been happening in Western countries where the deathmaking practices have often been legitimized by court rulings rather than by legislation.

*In 1994, the Supreme Court of India struck down a 161-year old law forbidding suicide. Immediately, death leaders in India demanded the legalization of "euthanasia" with the rationale that "India is overpopulated anyway; if a few people want to die, why not let them go" (IAETF Update, 9&10/94).

*A Norwegian social scientist believes that Norway and Sweden are moving in the direction of the Netherlands in accepting "euthanasia," in part in order to save resources. He also believes that as in the Netherlands, elderly people in Norway and Sweden are becoming afraid to go into hospitals (NC Register, 26/5/96).

*The Union of Orthodox Rabbis of the United States and Canada has called for a constitutional amendment to prohibit "euthanasia." We expect the union of reformed rabbis to be not far behind, demanding a constitutional amendment that permits "euthanasia" (Communiqué, 13/1/95).

*An award-winning Canadian journalist wrote a very long propaganda piece in support of "euthanasia" in Canada that was run in 8 installments in the Toronto Star starting on 15/10/94. The series includes pictures of Hoche and Binding, the German professors whose 1922 book became the bible of the German "euthanasia" movement.

*The first voluntary "euthanasia" law in the world was passed in the Australian Northern Territory (NT) in 1995, allowing both suicide assistance and direct killing of a supposedly terminally ill person who wanted it. Aboriginal leaders in Australia denounced the law as "sorcery," and said that the traditional way for aboriginal people is to "die naturally" (Celebrate Life, 9/96). An interesting feature of the NT law was that it required no more than the concurrence of a mere 2 physicians! As might be expected, the Australian press generally was laudatory of the development, and efforts to pass "euthanasia" laws are underfoot everywhere in Australia. The good news is that the medical association in the territory decided not to cooperate with the new law. However, the overturning of the NT law by the national government, and the outlawing of "euthanasia" in the

entire country in 1997, actually overrode the will of the people, in that active "euthanasia" is favored by a 2:1 majority of Australians (Australian, 9 July 96). One thing that the law and the controversy have done in Australia is to flush out a lot of people in revealing where they stand. In the short period during which the bill was in force, 4 people who wanted to die were killed by the same doctor. Interestingly, approximately 90% of Aborigines were said to oppose the bill, among other reasons from fear that they would be made its primary victims (Weekend Australian, 15/2/97).

Of course, whether legal or not, physicians in Australia, as well as all over much of the developed world, have already been practicing "euthanasia" secretly, or have supported it in large numbers. For instance, of physicians in the Australian state of South Australia, 12% admitted that they had already committed "active euthanasia" (Advertiser, July 29 & 30, & Aug. 10, 1992; source item from Peter Millier). Many Australian physicians also announced that the outlawing of voluntary "euthanasia" would not stop them from killing patients. We suspect that it will just be a matter of time before the 1997 federal law will be reversed because it goes in the face of public opinion in favor of death.

*According to an Australian physician, the greatest support for "euthanasia" for handicapped people comes neither from handicapped people themselves nor from medical personnel, but from relatives of handicapped and debilitated people who--when it comes right down to it--want to rid themselves of a burden (Speak Out, 3/96), once again underlining the conflict of interest issue.

*On the one hand, Australian AIDS activists there call for swift legalization of suicide assistance, while on the other hand, people with AIDS are afraid to go into a hospital for fear that they will be made dead without their consent by personnel who think that they would be better off that way. The Australian medical profession seems to be ready to start killing, with a third of physicians having indicated their willingness if only the law permitted it (AAP News, 9 Jan. 95; source item from Ross Wommersley).

*The former Queen's Governor General in Australia took the most unusual step of speaking to a controversial issue by publicly endorsing, at the same time, homosexual "marriages," adoption of children by such pairs, and voluntary medical "euthanasia" (LA, 8/95).

*Apparently, there is a much higher agreement with "euthanasia" in the population that is HIV-infected than in the population at large (Interim, 3/94). For instance, in Australia, the national organization of people who are HIV-infected came out in support of physicians who admitted that they had committed "euthanasia" (Communiqué, 5/5/95). At least part of the reason is probably that large segments of the population that is HIV-infected come from population sectors that have been at odds with traditional cultural values for a long time, which often had something to do with the fact that they then engaged in culturally-disapproved behaviors from which they acquired HIV. This population is also more apt to be put to death by health care workers, and again we have reason to assume that at least in part, this is because of their own acquiescence to "euthanasia."

*On 20 November 1994, CBS-TV's "60 Minutes" broadcast a story on Sue Rodriguez, the Canadian woman who had requested of that country's judicial system, and then parliament, that she be given assistance to kill herself because she had become physically incapable of doing it herself. She suffered from amyotrophic lateral sclerosis (ALS, or "Lou Gehrig's disease"), and because of the loss of nerve and muscle function that it causes, she would have been unable to take and swallow enough lethal pills, or to shoot herself. She eventually died in February 1994, with the (illegal) "assistance" of a physician whose identity she refused to disclose. After the courts (including the country's Supreme Court) denied her permission to kill herself, she asked parliament to take up the issue, and to change the law that makes such actions illegal. Part of her argument was that if she were able-bodied, it would be legal for her to take her own life, and so the law should permit assistance for those unable to commit suicide on their own. She invoked the usual modernistic arguments on her behalf, including the slogans "whose body is it anyway?" and "I have the right to control my life" and "my life belongs to me." She also said that it was "unfair" that she should have

to die in the admittedly gruesome way in which most ALS patients die, by suffocation, implying that people have a right to die in certain ways and that these ways should not be unpleasant.

Ironically, her case was seized upon by the head of the Canadian Society for the Right to Die, who wrote a letter for publication in a newspaper that he falsely attributed to Rodriguez, even forging a sort of signature of hers to it, illustrating once again the connection between violence and deception. Both he and Rodriguez seemed very sad examples of wounded people getting duped into endorsing and promoting deathmaking as a way to deal with their woundedness, and ending up as dupers. The head of the Society for the Right to Die said that without her case and without his involvement in the Society, he would not have a reason to live. And Rodriguez said that engaging in this battle had given her a reason to live!

A big puzzle is why "60 Minutes" would show that program when it did, since "60 Minutes" often times its broadcasts to coincide with a story that is on the current scene. There was no mention of the fact that the Canadian Senate was at that very time holding hearings on whether to make "euthanasia" legal. Nor was there any prominent "euthanasia" case in the news in the US. Rodriguez herself had been dead almost nine months. So why were they broadcasting the story?

*The New England Journal of Medicine first editorialized in support of patient killing in 1988, and within the next 7 years carried 8 pro-death articles, including killing guidelines.

*There has been a rash of revelations of physicians killing their patients in the US, Canada and Britain. In a case in Nova Scotia, the family had asked that life supports be withdrawn from a 65-year-old cancer patient, but instead, the physician administered a lethal injection, leaving the widow in a case of shock. In Britain, a former UN medical director admitted having "euthanized" about 50 patients over his 40-year career, and another physician admitted "euthanizing" 150 people over a 30-year period. As he put it, "When I decide it's time that they go...then they go" (IAETF Update, 6/97).

*Researchers at the University of Pennsylvania polled nearly 900 physicians who worked in adult intensive care units. Of these, 32% said that they had withheld or withdrawn life supports without consent of either the patient or the family, and 3% of these said that they had done so over the objections of patients or families (Communiqué, 7 April 95).

Only pro-death propagandists and the childishly naive could believe that modernistic physicians would ever refrain from killing on their own initiative if they thought they could get away with it, and no data set has ever been able to show it otherwise.

*The first national survey in the US of physicians on physician-assisted suicide, conducted in 1996, found that 6% of direct care physicians had given patients lethal injections or lethal prescriptions. One admitted to having given 150 lethal injections. One expert estimated that perhaps 1% of all patient deaths were physician-hastened. Physicians most likely to participate in "euthanasia" were internists, lung specialists and physicians serving the elderly. This was interpreted as being an uncommon event, but when one considers the millions of deaths in the US every year, the raw numbers are no longer so small. Perhaps most frightening was that one-third of all respondents said that they would be quite prepared to write lethal prescriptions if only it were legal (AP in SHJ, 23/4/98). This survey also brings out the confusion between "assisted suicide" and active "euthanasia," in that giving patients lethal prescriptions was all mixed up with giving them lethal injections.

*The fact that physicians are vastly more willing to perform "euthanasia" than the law currently permits has been cited by certain people as an argument that anti-"euthanasia" laws are "effective" (e.g., NRLN, 7 May 98).

*The Canadian Medical Association told the Canadian Parliament that the only way to find out how many physicians perform "euthanasia" is to give physicians immunity for doing it

(Communiqué, 23/12/94). This would be a most peculiar rationale: let physicians kill legally so that we can finally find out how many of them kill, and how many people they kill.

*In Michigan, physicians have formed a group in 1995 in support of "euthanasia" and Kevorkian, and called themselves "physicians of mercy" (CL, 1/96).

*One "good thing" about "euthanasia" is that even those physicians who commit it say that "it should not be undertaken lightly" (Time, 15/4/96). Gosh, like maybe whether or not to have that fourth cup of coffee in one day?

*The good news is that 88% of German physicians oppose active "euthanasia," and 45% do not believe that one can make a valid prediction about a child's future "quality of life" (Band, 1/98).

*Death doctor Anthony Quill asseverates that only physicians who work with the dying should be allowed to kill (CBS, 6 Jan. 1997). Perhaps only Nazis familiar with Jews should be allowed to kill them.

*Physicians who are in favor of "euthanasia" are apt to tell the grossest kinds of lies to the family members of a patient in order to get them to agree to some form of "euthanasia." For instance, relatives may be told that the patient had seizures that never occurred, had a stroke when the patient is in fact in a medication-induced quasi-comatose state, etc.

*There are increasing reports of elderly people being dehydrated and starved to death in hospitals merely because they are debilitated and elderly, but for no other reason. We have to be very clear that this is no longer even passive "euthanasia" but active. We also reiterate that these kinds of deaths are not at all painless unless the person is drugged into oblivion, and even then they are rather gruesome. For instance, people who are perfectly lucid may end up screaming for water that is never brought. Often, family members request that this be done in order to be rid of any burden of care or responsibility, or in order to speed up their inheritance. In some cases, there has not even been an NPO (nothing by mouth) order from a physician, and yet three shifts of nurses will go along with a family member's request for this kind of killing. In one case, a daughter of a woman being thusly made dead held an estate sale while the mother was still alive because she was in a hurry to get back to her own home in another state. The responses of health care workers have begun to shift from shrugging such things off with comments such as "she was pretty old," to "it happens all the time." Soon, the major argument in such cases will become--as it has partially already--that it is much more merciful to kill quickly and painlessly and neatly with a lethal injection (LA, 7/94).

*A hospital in England withheld nourishment from a woman for 8 weeks. When this failed to kill her, they started withdrawing liquids. After a week, her mother said, "If you can hear me, blink your eyes"--and she did. Upon which the mother stopped the killing, sued, and settled for £100,000 (23/6/98 info from Tony Wainwright).

*A woman in a Florida nursing home had given her brother a durable power-of-attorney and verbally mentioned to him that she did not wish to be put on a feeding tube. One day not long after, doctors decided that while eating she just might aspirate food and choke to death--whereupon with the brother's consent, the nursing home decided to starve her to death. (Remember detective Fearless Fosdick who shot people to death to save them from getting poisoned?) However, they apparently made one mistake, and that was to not simultaneously drug her into mental stupor, because the woman began to start begging all over in a most pitiful fashion for food. One nurse who waivered and gave her some milk was promptly disciplined. A nurse then told a priest about this who told it to a right-to-life group member who brought it to the attention of the state protective service. This brought the state attorney in who brought in a judge who signed an order to put the woman on a feeding tube while the case was under investigation. This was promptly appealed to

a higher court that ruled that the woman was not "not competent to ask for food," which is probably a new precedent. (This is a rather convenient ploy: if you want to kill somebody, you simply rule that the person is incompetent to know that he or she would be better off dead, and then go ahead and kill him or her). Her feeding tube was removed and she died. One rationale in any ruling that a person is not competent to ask for food is now that giving food is a medical decision, and of course, none of us nonphysicians are considered competent to make such decisions as to whether somebody should eat. Even spoon-feeding someone is now considered an "extraordinary" medical procedure. The nursing home also claimed that any person who was at risk of aspiration while eating and who nonetheless asked for food could obviously not be competent (NRLN, 24/4/95). Apparently, this sort of thing has now become quite common. Many states now permit withholding of food and water from patients who have not made their wishes known and who are deemed incompetent. Obviously, feeding a chronically dependent person is now considered to fall under the relatively new rubric of "futile treatment."

*There may not be quite as much deathmaking in Catholic hospitals as in others, but there definitely is some. For instance, a Catholic hospital in California starved a patient to death, and in a midwest Catholic hospital, a 93-year-old woman was kept against the expressed wish of her son who tried to transfer her to a hospice, and when she failed to die, she was injected with a lethal dose of Dilantin.

*Several hospitals in the Houston, Texas, area have gotten together and drawn up "ethical" guidelines that would permit health care providers to end the lives of patients against the wishes of the patients themselves as well as of their proxies. These guidelines permit deadmaking in those cases where the preservation of a patient's life "would not be compatible with the values of the institution." We continue to point out that patients are given the right to choose to die, but not the right to choose to live (NRLN, 14/11/96). Also amazing is that this can happen in broad daylight, and no one is being charged with a crime, such as conspiracy to murder.

*Michigan State University had the nerve to bid for a European patent on a "euthanasia" drug for "mammals." Currently, this drug is used on animals, but the university said that if it should ever become legal to use "the compositions in human beings, the patent claims should encompass the use of the present invention for this purpose." The drug is made by the same firm that makes RU-486, and that once made the gas for killing handicapped people and concentration camp victims in Germany (Life At Risk, 12/96). Veterinary "euthanasia" drugs are already available without any patent protection because of the small market for such drugs. Therefore, the prospective use of this drug for human "euthanasia" appears to be the only reason why MSU is seeking patent protection for it (IAETF Update, 12/96).

*In 10/94, there was yet another bioethics symposium in Syracuse (at its state medical school) with the title, "The Art of Healing When Death is Near," but 4 of the 5 topics covered dealt with killing people "at the end of life."

*A senior associate in clinical ethics of the Catholic Health Association came to Syracuse and announced that "I don't come into town to tell people everything they need to know. I don't see myself as bringing answers, I bring more questions, encourage discussion" (Catholic Sun, 19/10/95). There must now be several ten thousand ethicists floating around who don't seem to have answers for anything--except when it comes to deathmaking, when they all seem to agree that it is a good thing.

*The Harvard people are not even pretending anymore to give the usual "on the one hand, and on the other" conferences, but have begun to hold the out-and-out Harvard International Conference on Euthanasia in 1997. The conveners refused to permit handicapped people to speak (Mouth, 11/97).

*Australian death guru Helga Kuhse said that the main obstacle to public support for "euthanasia" is "ignorance about death and dying" (Weekend Review, 27/8/94).

*A most peculiar argument in support of "euthanasia" was employed by a German journalist who argued that in Germany, homeless people dying from alcoholism become an object of scientific medical study, guinea pigs for medical education and even subjects for drug experiments who are treated as anonymous case folders in certain beds, whereas in the Netherlands such a person would be treated as Mr. so-and-so, and after intensive consultation gently slipped away (Amerika Woche, 5 March 94). Of course, the claim that there is extensive consultation is a lie.

*The newsletter of the Los Angeles chapter of MENSA, the high-IQ society, has published articles advocating the killing of the mentally retarded, elderly, infirm, and homeless (Ottawa Citizen, 11 Jan. 95; source item from Ray Lemay). One MENSA member argued that "the vast majority of the homeless are too stupid, too lazy, too crazy, or too anti-social to earn a living." "What good are they?" They "should be humanely done away with, like abandoned kittens." The infirm were characterized as "a piece of meat in the shape of a man" (IAETF Update, 1/95).

*Mouth (11/96) reported a rather chilling and moving instance where 2 handicapped people who attended a meeting of a local chapter of Choice in Dying ended up being screamed at by 250 participants that in effect they would be better off dead.

*On the one hand, one may think one is reassured to hear deathmaking philosopher Peter Singer saying that "euthanasia" should only be considered "as a last resort." But on the other hand, that would still mean that he would be prepared to see several million people slaughtered every year if his criteria were applied worldwide (NRLN, 7 May 1991).

*How-to-live guru M. Scott Peck opined that "we are not yet ready" to deal with "euthanasia," which of course is a way of saying that there is nothing intrinsically wrong with it, as long as the societal sentiments are right (Newsweek, 10/3/97).

*Opponents of the trend toward "euthanasia" have pointed out that it is most peculiar that the US is moving toward defining a right to be killed and a right to be helped to kill oneself before it has even defined a right to receive medical care.

*For once, CBS TV's "60 Minutes" of 3/3/96 carried a life-defending episode, contrary to its usual custom. It told the story of a son who kidnapped his demented father from his mother and the rest of his siblings, all of whom wanted to see him killed "for his own good" but apparently against the father's own wishes.

*There is a new twist to medical "euthanasia" that had escaped us until now. Namely, if a physician kills a suffering patient with a lethal dose of painkiller, there is hardly any chance of the physician being subjected to legal consequences. However, if the physician uses a substance that is intrinsically lethal and is not used for medical therapeutic purposes, then the physician is apt to be prosecuted (The Economist, 17/9/94; source item from John O'Brien).

*No sooner had the voluntary "euthanasia" referendum passed in Oregon than activists in the state, including state officials, began working on the legalization of involuntary "euthanasia." Also, Oregon state prosecutors announced that they will not prosecute a physician who ordered a lethal injection for a patient who had never requested "euthanasia." Further, the Hemlock Society of the US came out in 12/97 for the first time--at least publicly--in favor of legalized involuntary "euthanasia." As an example of such a justified instance, the case was cited of a 61-year-old man in Louisiana shooting his 90-year-old father to death who had "Alzheimer's disease" (Life At Risk, 12/97).

*The health and medicine writer of the Syracuse Herald-Journal wrote an article in that newspaper (2 Feb. 95) headed, "Pets and people deserve a humane, comfortable end," meaning of course "euthanasia."

*We were amused by the 12 March 95 episode on the hospital-set TV series "Chicago Hope" in which physicians announced that they had to kill someone to save him. This not only sounds like the Vietnam War all over, but also like the entire assisted suicide and "euthanasia" argument.

*On 29 December 1994, yet another deathmaking episode of the TV medical show "Chicago Hope" was broadcast. It's getting to the point where the only thing remarkable is when one of these shows does not broadcast a program that endorses deathmaking! In this episode, a doctor with inoperable brain cancer who was in a coma and had asked for a "do not resuscitate" order was being administered morphine in her intravenous drip at a rate which would kill her--and indeed, this was done intentionally by a physician who wanted her to die without pain and in peace. When the physician ordered a nurse to increase the morphine, she refused, the case went to a hospital ethics committee, and then to court. The court denied the request to "euthanize" her, but she died shortly after with suspicion remaining that another physician in the hospital had secretly administered a lethal dose of morphine. Throughout, phrases were thrown around about her being "vegetative," "de-corticated," that "this happens all the time, it just usually doesn't become public," and that this is all done out of compassion for patients.

*On the computer Internet, one can now access a DeathNet site which will tell one all one needs to know to commit suicide, "help" somebody to die, or perform "euthanasia." There is some speculation that alienated teenage computer nerds will be more likely to commit suicide because of their access to DeathNet (IAETF Update, 3/95).

*Thank goodness, the Washington Times (22/10/94) said something to the effect that if the current "euthanasia" trends continue, before long, there would be a whole cable channel devoted exclusively to death-and-dying content.

*There is something closely akin to a pro-"euthanasia" hymn, written in 1984 and entitled "God, Let me Welcome Timely Death" (FT, 5/97).

*On the night of 27 April 1995, the TIPS editor dreamt that he was a patient in a hospital, but in relatively good shape and able to walk around. Along came a doctor making rounds--with a shotgun on his shoulder. He was looking to see if anybody should be put out of their misery. When the TIPS editor asked him when his time might come, he said, "Oh, perhaps about three years from now." Then the TIPS editor awoke. Are these going to be the nightmares about medical care we will all have?

*Starting in about 1996, a reaction against the "euthanasia" wave appears to have set in even in liberal circles. However, because it does come from liberal circles, this opposition is deeply flawed. What one hears is that the arguments for "euthanasia" are not very logical, or are even lacking in factual veracity, that society is "not yet ready" for "euthanasia," that safeguards would not be adequate, and so on. What is suggested instead is not a radical opposition to the idea itself, but either that the debate should continue until a clearer consensus emerges, that safeguards should be more carefully thought through, or that "euthanasia" should be practiced informally and quietly in extreme cases by well-meaning physicians, but should not be legalized.

*The danger of giving too much weight to patients saying that they want to die was brought out by a study (American J. of Psychiatry, 8/95) that such expressions may greatly change in as little as two weeks--and yet in the Netherlands, two-thirds of all "euthanasia" deaths are inflicted within two weeks of a patient's request (Life At Risk, 11/95).

*A woman who had children over 30 years ago said that she had never had as much pain as during childbirth, and if anybody had asked her then if she would prefer to be put out of her misery, she would have gladly taken them up on it. She said that she is thanking her lucky stars that no ethicists were prowling the halls while she was screaming her head off (Mouth, 3/96).

Updates on "Euthanasia" in the Netherlands

We continue our coverage (in earlier issues) of the massive medical killing in the Netherlands. That country is now the world leader in this respect.

*The "euthanasia" situation in the Netherlands is very comparable to its drug situation. According to Dutch law, cannabis is an illegal drug, and yet in 1976, the Dutch adopted a formal written policy of nonenforcement of drug possession up to 30 grams, which is enough for at least 3 months for most users. This policy of passing laws on a serious issue on the one hand, and then nullifying them with de facto policies on the other, probably laid the groundwork for doing the same on "euthanasia," in keeping it illegal on the one hand while tolerating it--and ideologically even promoting it--on the other (Science, 3 Oct. 97).

*It is probably no coincidence that in the Netherlands, there is a severe problem of drug addiction (especially by young people) at the same time as the country is killing its ailing, handicapped and elderly population. Unable to remember any shared values, the Dutch reportedly cannot agree on anything, and even the dikes are eroding because people cannot agree on what to do about them (Life At Risk, 10/95).

*Even psychiatrists have started getting into the killing business (Seduced by Death). Presumedly, they would otherwise feel left behind by the rest of the medical profession.

A recent book (Seduced by Death) called medical killing "the Dutch cure." The book also pointed out that often, it is the physician who first suggests "euthanasia" to the patient, rather than the other way around.

*According to one study of 3,300 patients who were put to death by their doctors in the Netherlands, 13% had never even mentioned the "euthanasia" issue to their doctors, and in about a third of the cases, the killing was performed without an unequivocal consent of the patient. In our opinion, these figures are conservative, and could be much worse. One Dutch expression these days is "termination of the patient without explicit request" (Seduced by Death).

*About a third of the people with AIDS who die in the Netherlands were "euthanized" or received suicide assistance (Toronto Star, 16/10/94).

*Increasingly in the Netherlands, children who ask for it may be put to death by their physicians without consent from the parents (CRTIR, Spring 95).

*Courts in the Netherlands have come up with the peculiar concept of "justifiable murder," applying this to the medical killing of a severely handicapped baby (Communiqué, 19/5/95).

*A Dutch physician gave a Catholic nun a lethal injection during her terminal illness even though she did not ask to be put to death. He later said that he assumed that she would have wanted to be put to death if only her religion would have allowed it (NRLN, 17/5/95).

*In the Netherlands, some families observe the killing of one of their afflicted family members in a fashion analogous to baptisms, confirmation, weddings, graduations, etc. Also, they schedule the killing so far and precisely ahead that in discussing upcoming events with them, they may consult their calendars and announce. "Oh no, I can't come to a meeting next month because that is when my (father or whoever) dies." (Source info from Kristjana Kristiansen.)

*In Western countries it is considered barbaric to have public executions, but in the Netherlands, the TV in 1994 showed a medical killing by injection of a sick man, in his wife's presence (Advertiser, 22/10/97; source item from Peter Millier).

*In the Netherlands, medical killings have not only become normative and legitimate, but penal law has begun to speak of the "necessity in individual circumstances of ending a patient's life" (Communiqué, 5/5/95). Some people have said that deathmaking ideology in the Netherlands has reached the point where the "right to be killed" has become "the duty to get oneself killed." A woman in a hospital was secretly and precipitously killed by a physician who was a stranger to her because he wanted the "bed" for someone else (Reader's Digest, 9/97).

*In 1995, the Dutch Supreme Court ruled that "euthanasia" "could be necessary" for some people on account of their mental disturbance, but before putting such a person to death, a physician should get a second opinion--and unlike with physically sick or old people, "the independent expert should actually examine the patient" (FT, 10/95).

*The Dutch health ministry is trying to have the licenses revoked of those physicians who refuse to refer patients to doctors willing to perform "euthanasia" (IAETF Update, 11&12/94).

*Paradoxically, in the Netherlands, "euthanasia" by anyone other than a physician is a criminal act because "euthanasia" is defined as a medical procedure which a doctor may not delegate (LA, 5/95).

*One of several slippery slopes onto which the Dutch placed themselves is that "euthanasia" was supposed to be administered only by physicians, but once these were able to do it freely without fear of negative consequences, non-physicians began to do it as well (CL, 7/96). In one Dutch hospital, a nurse killed four elderly handicapped people with secret and unordered injections of insulin, which shows what kind of things are going on there (Communiqué, 20/10/95).

*"Euthanasia" was first allowed in the Netherlands in order to give people more control over how they died, but the outcome has been that they now have less control than ever over the circumstances of their death, which is one reason why many of them have begun to carry "Passport For Life" wallet cards in hopeful efforts to protect themselves from being put to death if they should become mentally incompetent or comatose (CL, 7/96). These cards say that one does not want to be put to death (CRTIR, Spring 95), and a lot of handicapped people have started carrying them. We doubt that this will be of much use to them.

*The Dutch are apparently having second thoughts about having the killing of vulnerable persons done by physicians, even as they are unrepentant about the merit of such killings. So instead, there is now a movement underfoot to have physicians give patients access to lethal drugs, but not do the killing themselves, instead letting the patients kill themselves--and, we would assume, possibly in many cases with the assistance of friends and family members. All of this would undoubtedly diminish the fear people have been developing of physicians and medical treatments (LA, 10/95).

*One of the most prominently visible promoters of "euthanasia" in the Netherlands has been Dr. Admiraal, but in 1994, he admitted that he is afraid that when he gets old, younger people will want to kill him (FI, 6/95).

*We had a sudden insight as to why the Netherlands is leading the world in legitimized medical killing of its handicapped population. For many years after the war, the Netherlands had a post-primary production economic system with policies that very actively encouraged dependency and unproductivity. In its population of over 14 million people, only about 4 million worked, and about 1 million were receiving public subsidies for purported ailments and handicaps, many of which were imaginary or fraudulent. Obviously, the country produced such a surplus population of

dependent people that a reaction set in which, without being explicated, set in motion the systematic reduction of this dependent surplus population through medical killing. This is, of course, only a hypothesis, but it is otherwise rather difficult to explain the Dutch phenomenon, and killing off all elderly and dependent people is certainly one way to conserve the material wealth of a nation.

*One consequence of the massive deathmaking of debilitated people in the Netherlands is that the hospice movement there is virtually nonexistent. This is because a person who in the US would become eligible for hospice services would in all likelihood be made dead in the Netherlands. (From a document submitted by Lynn Breedlove.)

Tissue & Organ Transplanting as a Utilitarian Motive for "Euthanasia"

*It has taken some time to see more clearly that the desire to "harvest" fresh organs was actually a major motive in the promotion of so-called brain death criteria, because these criteria would allow organs to be taken from people who de facto are still alive.

*A study reported in the 6/98 issue of the journal Pediatrics claims that the number of suitable juvenile organ donors could rise 42% if organs were taken from patients before they were declared brain dead (Indianapolis Star, 2 June 98; source item from Joe Osburn). Obviously, in light of the contemporary talk about the great need for organs and the limited supply of them, such a study will fuel the practice that has already taken place of declaring people dead before they really are dead in order to take their organs from them.

*There are people who claim that 20 million Americans have afflictions that could benefit from fetal tissue transplants. One enthusiastic proponent likened fetal tissue techniques to what superconductivity is to physics. Some commentators believe that this is propaganda designed to make abortion, and the butchering of aborted babies, more acceptable (NC Register, 3/98).

*In some hospitals, when family members fail to agree to donate the organs of their critically ill family member, the level of medical care for that patient may be drastically curtailed. On the one hand, this may be a form of blackmail to pressure the family into agreeing to organ donation. On the other hand, it may signal that the health of the patient's organs is no longer of interest to the physicians. One mother told us that when her teenaged son was in the hospital dying of kidney disease in 1996, he received excellent care as long as the medical personnel thought there was a chance that his family might agree to donate his organs for transplant. When the family said no, the medical care immediately declined, and the head physician explicitly told the mother that this was being done in order to get the family to agree to make him an organ donor because he was "prime harvest ground." In other words, they were resorting to a form of deadly blackmail in order to get the organs that they apparently thought were rightfully theirs.

*In mid-1996, we were told that the mother of a young man who was critically injured in an automobile accident, and who was expected to die within hours or days, was approached repeatedly by hospital workers--in her words, they came at her every half-hour--wanting her to sign forms so that his organs could be taken for transplant. On the one hand, this was surprising, considering the type and severity of his injuries, which probably rendered many internal organs useless. On the other hand, it was absolutely heartless, in relentlessly intruding on the suffering of grieving people. The mother was reported to be very bitter at the hospital because of this.

*A young adult who had been mentally handicapped from birth was hit by a car, and at the hospital, where it appeared he would die, his parents were asked to agree to donate his organs because, said the physician, "Your son has been of no use his whole life, why not make him useful now?"

*In 1997, parents of a handicapped child told us that when the child got sick, physicians pressured them to sign away the child's organs with the argument that they would thereby "make a useless child's life meaningful."

*Some ethicists began to announce in 1997 that failure to fill out organ donation instructions amounted to homicide, and therefore was a "moral imperative," not to mention that failing to donate one's organs amounts to "feeding them to worms" (CBS TV "60 Minutes," 1 June 97).

*A new law in Brazil declared that authorities can take the organs of people who die, regardless of what their relatives may wish, unless the deceased had specifically stated on their official identity cards that they opposed the practice (BRMM, 11/97).

*A British working party composed of most prominent personages recommended that lethal injections be given to people in a "permanent vegetative state" so that their organs can be "harvested" (Speak Out, 11/97).

*Since about 1991, the number of organ transplants has not increased greatly, while the demand has. This has contributed on the one hand to an increasing organ market and, on the other hand, an ever more frantic effort by the organ industry to generate organ sources (AW, 28/6/97). Rich people are most likely to buy organs in India or Brazil. Usually, the middleman gets ten times as much money as the person who sells an organ, particularly since the organs are sold by the poorest of the poor who are fairly helpless vis-à-vis the manipulation of organ entrepreneurs.

*It may be only a modernistic legend, but in many poor countries, poor people are convinced that children are being abducted in order to be butchered for their organs (e.g., AP, in SHA, 27/8/95). We consider this to be a plausible scenario.

*The evidence has become overwhelming that China has been selling organs from executed prisoners, and that the Chinese have been lying about it all along. What else should we have expected from people who eat dogs?

*In 2/98, several men from China were arrested in New York while trying to sell human body parts (e.g., up to $40,000 for a liver). These parts would undoubtedly have come from the 6,000 people executed for crimes in China every year (LA, 5/98).

*Even the normatively deathmaking-promoting CBS TV program "60 Minutes" admitted in 13/4/97 that organs are being taken from hospital patients who are "not quite dead."

*A Princeton biologist argued, "These human bodies without any semblance of consciousness would not be considered persons, and thus it would be perfectly legal to keep them 'alive' as a future source of organs" (Time, 19/1/98).

*A Tennessee judge has been offering convicted offenders a reduced sentence if they will sign organ donor cards (NC Register, 3/98).

*A mentally retarded man, asked if he wanted to sign an organ donor card, said "I've been generous all my life, but if I sign this, they might not try so hard to fix me." Wisdom from the lowly!

*It is a sign of the times that just as medicine is desperate for bodies for organs and tissues, Hollywood would make a movie ("Extreme Measures," 1996) on medics snatching not only bodies, but still-live ones.

*One way in which we have seen heart transplants detoxified is by saying, "the heart is a pump."

Incidences & Issues of Instituting, Terminating or Continuing Treatments & Life Supports

Earlier items already touched on this issue. Here are more items specifically dealing with it.

*People are very confused abut the morality of rationing medical care. The fact is that by the very nature of things--i.e., resources never being limitless--there is and will be such rationing. Thus, the issue becomes whether the criteria for rationing are moral ones. Unfortunately, in the contemporary context, such rationing is highly apt to be done on a materialistic utilitarian basis. An example is the fact that, according to Wess (1998), people over age 60 no longer can get dialysis in Britain unless they pay for it themselves. A scheme called the Rosser matrix is employed to decide who gets what medical treatment, and it is based on what a person is judged to contribute. Thus, children are favored, because it is presumed that they will have a productive life ahead of them. Children are given a "worth" of about £1 million. In contrast, pensioners are given a "worth" of 0, because they are no longer producing. Similarly, an operation that will liberate a person from pain and impairment is more favored than one that will leave a person still handicapped, or still in pain.

Relatedly, there has been a "life and death game show" in Britain in which the audience is presented with various "ethical dilemmas" concerning who should receive medical treatment. Real people appear on the stage in a spotlight, and tell their story and make their case why they should receive a certain treatment at public expense via the national health scheme. The audience is then given a few seconds to decide which of the "contestants" should receive the treatment. The "contestant" who "wins" remains in the spotlight, while the "losers" disappear into darkness--a sort of symbolic death for them. However, even once a "contestant" "wins," there is no guarantee they will receive the treatment, because "winning" "contestants" then go on to another round, where they compete against new contestants (Wess, 1998). Obviously, this show--whatever its stated intent--is in fact desensitizing the audience to moral issues of medical decision-making, and brainwashing them to decide in favor of "productive" people.

*In 5/98, we were told that at least in some US locales, or under some health plans, people who have received a diagnosis of "Alzheimer's disease" are not likely to get approval for any kind of Medicaid-funded active medical treatment, even of a generic nature such as antibiotics. To the degree this is the case, it is thus in the interest of people acting in defense of life to do what they can so that their elderly loved ones (or advocatees) will get some other kind of diagnosis, such as "senile dementia" or "arteriosclerosis."

*One is amazed to learn that the journal American Family Physician, published by the American Academy of Family Physicians, provided an analysis of advance directives which included the statements that "people who need a lot of help with daily activities, people who have severe infection such as pneumonia that require hospitalization," and several other groups "are not likely to benefit from CPR" (Communiqué, 23/12/94). This is one of the most grotesque interpretations of the meaning of the phrase "staying alive," which is the benefit of CPR.

*We are amused by how a judge resolved the issue of whether an elderly mentally retarded man should or should not receive an operation that might be life-extending, when this issue was brought to court. There was a lot of quality of life talk, as there often is when people are trying to pull somebody's plug. The judge applied some very culturally normative criteria to this issue by asking whether the old man could eat ice cream. When he was told that this was the case, he then asked whether the old man liked it. When he was told that this was the case as well, he ruled that the operation should be performed, because he concluded that this meant that the old man was capable of enjoying "quality of life."

*It is amazing how some of the most insensitive people talk about being sensitive to others, their cultures, etc. Imagine you are eating and are suddenly choking to death on a piece of food. Imagine further that there are all sorts of people around you who will stand by or sit by and calmly do nothing while staring at you as you slowly die. Surely, this would add sheer terror, and perhaps even an element of disbelief and hatred, to the last two minutes or so of one's consciousness. Choking to death is a terribly frightening thing, and how can people who said they loved one and cared for one, and perhaps were even paid for it, refuse to do anything about one's choking even when one begs them through gestures. Yet that is exactly what more people are demanding, i.e., that the Heimlich maneuver not be performed on vulnerable people such as nursing home residents, and particularly not where the family has requested that no extraordinary measures be employed. Of course, the Heimlich maneuver is not extraordinary since almost anybody can do it. (Lawrence Tribune (MA), 11/94: source item unfortunately not only from then Nancy Killam, but she also lived on Kilren Road which, as she put it, "doesn't help either"; she has since married, is now Nancy Rampulla, and has a better address.)

*Mouth (11/96) claims that in Houston, the birthplace of advanced trauma care, emergency medical personnel will no longer administer CPR because "too many people are being saved." Also, across the US, attendants with home care agencies are often no longer allowed to perform it on the handicapped people whom they serve, even when they are certified to do it.

*A group of physicians has claimed that the public has been getting a totally false image of both how cardiopulmonary resuscitation is conducted, and how effective it is. On TV, or in films, it is usually conducted on younger people who are victims of near-drownings, car wrecks or shootings, it does not inflict injury, and is usually successful. In real life, the procedure is much more gruesome, often does a great deal of harm (e.g., breaking ribs), and is most commonly done on people who end up dying anyway. One consequence of the media distortion, these physicians claim, is that more people say they want to be resuscitated than would if they knew the truth (AP in NY Times, 17/6/96). We suspect that this is a combination of truth and pro-death propaganda.

*A Johns Hopkins study claimed that when patients with supposedly terminal cancer suffer a heart attack and are resuscitated, they die anyway within an average of eight months, and each costs nearly $400,000 in additional medical costs. It is rather telling for our age that instead of raising the question whether the resuscitation is disproportional in its traumatic nature in relation to the likely success in benefits, the discussion focused on how much money was in effect "wasted" on these patients (SHJ, 28/9/95).

*Some critics have claimed that the term "futile care" or "futile treatment" really means that one is too expensive (Mouth, 9/96).

*After even the most successful operation (which is a truly heroic one to endure and extremely difficult and delicate to perform), the survival time of people with certain brain tumors is on the average extended only from five months to 18 months (Time, Fall 1997), and yet because this is high-tech and glamorous, no one refers to this as "futile treatment," even though futility talk gets thrown around with great glibness in respect to all sorts of other treatments and life conditions, even where life expectancy is much longer.

*It is deeply symbolic that the US Federal "Patient Self-Determination Act" was passed in 1990 as an amendment to the Federal Budget Reconciliation Act. While officially, this was done merely as a convenience, it still symbolizes the economic motives in getting patients and their families to sign away the patients' lives.

*In 1/92, the Massachusetts Supreme Court ruled that a feeding tube could be removed from a severely retarded woman at one of the state's mental retardation institutions. Right away, the Boston Globe announced that "severely retarded patients given the right to die" (7 Jan. 92).

Similarly, a 9/98 Va. court ruled that a wife and law guardian were authorized to have the comatose husband's feeding tube removed, and starve him to death, even though he was said to have spoken to a nurse. The ruling was reported in a headline as a "right to die" case, when it was really a "right to make someone else dead" case (AP in SHJ, 22/9/98). The pro-death deceptiveness of the media is boundless.

*There is a computer program that allegedly "predicts" whether a patient will live or die, based on objective variables of the patient's current condition. People in England were upset to learn that it is being used in intensive care units, but the physicians said that they did not use it to determine treatment, only to predict--and that it was right 95% of the time (received from Rob Henstock 9/96). However, a study then found that the program had a large error rate. Of 53 patients who were predicted by the computer to have an almost 100% chance of dying, 16 survived (AW, 15/3/97).

*Feeding someone through a tube is sometimes called "artificial feeding," and this phrase begins to generate a deathmaking mindset because people begin to equate it with such things as artificial respiration. Also, the term "artificial" conjures up images of very "extraordinary" means. However, in tube feeding, about the only thing that is artificial is the tube. The food is very real even if pureed, and so are the processes of digestion. About 850,000 people in the US use some type of tube feeding every year, some of them while holding full-time jobs, and many of them are able to feed themselves through the tube! In fact, one man in a motorized wheelchair poured eight beers down his feeding tube, and then got arrested for drunken driving (LA, 7/94).

*In Germany, 43% of physicians advocate withholding any form of active treatment from severely impaired newborns, and less than half of these would try to involve the parents in any such decision-making. However, if parents do actively pursue treatment, then it will be provided in 87% of cases (Band, 1/98. This underlines that unless the parents are very forward in pursuing treatment, chances are very high that their baby will be made dead behind their backs.

*It was found in a survey that hundreds of physicians said that they would recommend withholding expensive medical care from babies born to HIV-positive mothers even if the babies were not HIV-positive (Colorado Lifewatch, 3/96). Obviously, the only issue here is one of cost consideration rather than health status or prospects of the baby.

*Reportedly, 70% of hospital deaths in the US occur after a decision has been made to withhold active treatment (Mouth 5/98). Whether this is good or bad depends on other factors which one would need to know.

*A nurse reported in one of the major nursing journals how Mr. Levine, a 73-year-old man, was starved and dehydrated to death in a veterans' hospital in New York, which took him 20 days to do. The article reported in glowing terms how nice and friendly the nurses were to the dying man, and how hard it was on them to torture him to death over such a long period of time. "We are proud of the fact that we were able to provide compassionate and quality nursing care. We are also confident that we will be able to meet whatever challenges future Mr. Levines may bring" (FT, 2/98). This sounds amazingly like the killers of Jews and handicapped people in Nazi Germany bemoaning how difficult their task was, carried out only because it was a duty, how they often had no hard feelings toward their victims, and how they may even have loved them if they were handicapped.

*A 15-year-old Florida boy who had already gone through two liver transplants and was scheduled for a third demanded to be left in peace and to die without being forced to go through a third transplant. He had received his first liver transplant at age 8, and the chance of the third one giving him even one additional year of life was estimated to be less than 50%. The anti-rejection drug he had been taking made almost every minute of his life miserable. Someone from a high-tech

medical transplant team called a child abuse hotline, which triggered a war-like campaign against the boy. The state sent 5 police cars, 2 ambulances, and a crew of social workers to catch the boy and force him into a hospital. The boy screamed, kicked, and knocked out a window with his elbow before being tied to a stretcher and loaded into an ambulance. At the hospital, he refused blood tests, a biopsy, and anti-rejection drugs. After four days, the judge ordered him released. Theoretically, his parents could have forced him, but they desisted, and after spending a few weeks the way he wanted to, he died (Time, 27/6/94).

*In German, the so-called persistent vegetative state (PVS) is called the "waking coma."

*In 1994, a task force of the American Academy of Neurology issued a report endorsed by the entire academy that a so-called "vegetative state" can be considered to be "permanent" if it lasts 12 months or more "after traumatic injury," despite the fact that there is a continuing documentation of recovery of consciousness in a very significant minority of persons with that kind of consciousness impairment (Life at Risk, 1/96).

*The German medical society wrote new medical deathmaking guidelines in 4/97 that allow withdrawal of life supports from people in PVS (Source clipping from Carsten Krüger).

*Physicians in a Georgia hospital argued in 1991 that the only thing a comatose child could feel was pain, and that keeping her alive constituted child abuse. Thus, theoretically, the failure of the hospital or the physicians to make the child dead would be a legal offense reportable through child protection agencies (source information from Ray Lemay).

*Some severely mentally damaged people who some experts have claimed to be without awareness have been interpreted as acting like "trained animals" when caretakers testified that the person was able to emit some conscious responses (Life Advocate, 1/98, p. 41).

*One interesting phenomenon about the so-called persistent vegetative state is that the medical experts almost all claim that the affected person has no awareness, while a large percentage of people who spend years caring for such persons come to the conclusion that there is some awareness, and that certain responses which at first they thought were coincidence are actually manifestations of their awarenes.

*A man in England was diagnosed as being "permanently unconscious" even though he was fully aware of his surroundings, and this situation endured for two years before his mental capacities were recognized and he was able to learn to communicate through a computer keyboard (Speak Out, 3/97).

*A 13-year-old English boy thought to be "brain dead" after a traffic accident was nurtured back to consciousness by his twin brother who showed him videos, never left his brother's bedside, and was the only family member to know that his brother could flicker his eye. Once the family agreed to a tracheotomy operation so that the boy could be without a ventilator, he immediately began to improve. Eventually, he returned home and to school (Disability Awareness in Action (UK), February 1997, p. 9; source item from Katrina Kurowski).

*When a man came out of a 7.5-year coma, a clever deathmaking bioethicist embarrassed by this event said that surely, people would not want to be kept alive if they knew that they would have to endure a 7.5-year coma before regaining awareness (Newsweek, 26/2/96).

*Sometimes, after someone comes out of a coma--and only then--the deathmakers deny that it was a real coma in the first place (e.g., Newsweek, 26/2/96).

*Someone pointed out to the TIPS editor the interesting contrast between the medical profession's humility, in being reluctant to pronounce anyone who has had cancer "cured," and its arrogance in being very willing to proclaim that someone in a coma or so-called "persistent vegetative state" will definitely never recover. When a person has had cancer, but no longer shows any signs of the disease, the medical profession will talk about "remission" and "being apparently cancer-free," but never (hardly ever?) do they pronounce someone cured of cancer. Apparently, they do this in order to avoid embarrassment, or worse, if the cancer should reoccur, which many cancers do. In contrast, the medical profession does not seem at all reluctant to say about a comatose person that he or she will never come out of it, even though there are many incidents (and they continue to occur) where precisely this has happened. Perhaps one of the things that is at issue here is that because medicine wants to make dead very handicapped people (such as those in comas), it really does think and act like an omniscient God.

*Quite likely, physicians who want a patient dead will say that the person is in a PVS, or even "brain-dead," as no more than a way of using their authoritative position and expert status to get someone made dead. For instance, of 40 patients diagnosed as being in PVS, 43% were found in a follow-up to be aware, alert, and often able to express a simple wish (multiple 1996 sources).

*Apparently comatose from a gunshot wound to the head, a woman in a Ft. Worth, TX hospital was dreaming that a mean nurse was planning to kill her. Apparently, the dream was based on a conversation that took place at her bedside where a physician was talking to her mother about donating the wounded woman's organs after the life supports were withdrawn. Minutes later, the wounded woman began to rally, and only 26 days after having been shot, she walked out of the hospital (Fort Worth Star-Telegram, 5/1/93; source item from Christina Dunigan).

*A woman in a coma in a nursing home was raped by a staff person, got pregnant, and delivered a baby by natural birth (AP in SHJ, 19/3/96). Surely, one cannot be "brain dead" and yet bear a live baby!

*The fact that handicapped people are increasingly interpreted as terminally ill--and thus in a dying role--is evidenced by the fact that all around us, there are efforts to get people to sign "Do Not Resuscitate" orders for people who have some kind of a handicap, such as formerly were only sought for people considered to have terminal illness.

*A 37-year-old woman of very marginal identity, with multiple mental and medical disorders, and a history of alcoholism, drug abuse, homelessness, and several institutionalizations, was referred to a hospital emergency service where she took a lethal overdose of her own asthma medication. At this point, she was involuntarily committed to the psychiatric service. When physicians attempted to institute emergency procedures to deal with the drug overdose, she refused these treatments, and her refusal was accepted--whereupon she quickly went downhill, went into an uncontrollable seizure state and died (Quality of Care, 8/96).

*A school district in NY decreed that handicapped children in a special class who have a DNR on them could not be resuscitated if they went into a crisis (SHJ, 12/3/98). Imagine: a whole class of handicapped children staring in confusion and compassion as a friend chokes to death, suffocates, has a heart attack, or whatever, and the teachers do nothing and tell them to be quiet and let the child die!

*At a gathering of nursing home operators, it turned out that a large number of such homes had 100% of their residents on DNR orders (Mouth, 11/96). Obviously, to get 100% of one's residents to agree to this means that some kind of subterfuge must have been used.

*One of the peculiar developments in the surrogacy decision-making culture is that in some jurisdictions, the decision-making can be delegated by a person, via an advance directive, to people

who have all sorts of conflicts of interest, including directors of agencies that serve one. Yet furthermore, in some jurisdictions, such decision-makers are given immunity against lawsuits for making whatever decisions they make.

*There have been moves underfoot to declare parents of adults who had been mentally incompetent since they were minors the automatic continued guardians after the minor comes of age. Interestingly, this move was undertaken so that such parents would have the authority to have life supports withdrawn from such a child without courts appointing a guardian ad litem to determine the handicapped person's best interest. A court ruling in Minnesota in 1994 in the so-called Butcher case (quite appropriately, the name of the family) seems to endorse this concept. It led to the parents in this case authorizing the unplugging of their handicapped son from an artificial feeding tube, and letting him die over 11 days--all closely observed by media cameras (NRLN, 18/11/94).

*There is a physician in Canada who has been described to us as the Canadian equivalent of the US's Dr. Jack Kevorkian, i.e., "Doctor Death." One of our associates had contact with him about obtaining medical care for one of the handicapped people under her care. He wanted to withhold treatment so that the handicapped man would die, and he told her, "You're just keeping organs alive," meaning that by insisting on treatment for this man, she was keeping alive just a collection of organs that could be used (via transplantation) by other people, presumably ones he judged more worthy of life. Our associate and the agency she works for had been trying for nearly 20 years to locate this handicapped man's mother, to reestablish contact for him with her, but without success. Remarkably, the hospital that was trying to make him dead managed to find her very quickly, and did so with the express and only purpose of having her sign away consent to treatment so that he would end up dead.

*It used to be that a "no code" in the hospital meant "no resuscitation efforts if heart or lungs fail." But now, in some hospitals, the meaning has quietly been changed to also mean stopping food, water and antibiotics (LA, 2/95). Individual families who signed a DNR when it had its traditional meaning are not aware that since they signed it, the meaning has been changed to virtually actively killing a person.

The gist of it all is that nowadays, no moral agent should ever sign or approve of a DNR order. Instead, one may specify in considerable detail what procedures it is that one does not want to have employed. For instance, one would have to specify "no surgical incisions," or "no forceful chest compression in a cardiac or respiratory emergency," etc. One would probably also have to add that all standard procedures under similar conditions performed on healthier and younger people should be performed unless they have been listed in the above enumeration.

*To reiterate an item mentioned earlier, a woman who specified that she did not want to be "tube-fed if she was dying" was denied all nutrition when she had a stroke, even though she was not dying, and asked for food. The case landed in court where a judge ruled that she was incompetent to rescind her advance directives--and she was starved to death (3/96 clipping from Susan Gatautis).

The lesson here is that contrary to what one is told, when one has first indicated some retreat from treatment, when the time comes and one changes one's mind in favor of (more) treatment, one is apt to be ruled incompetent to retract.

*An emergency medical service technician in Rochester, NY, confessed that drivers of all 3 ambulance companies in Rochester had forged a secret agreement that ambulance personnel would decide for themselves which of their patients should be resuscitated. For people deemed "handicapped," no strong effort for revival would be made. Undoubtedly, other such secret pacts and conventions exist elsewhere.

*At some hospitals, it is standard policy not to resuscitate anybody who is on a ventilator, including handicapped people who come to their emergency service who may have been on ventilators for 10 years (Mouth, 5/96).

*In 1995, a very healthy but also very aged woman in a Syracuse area nursing home began to choke on some food. Somebody grabbed her and brought her up to the nurses station where the nurse said that the woman had a DNR on her and decreed that she should continue to choke to death, which she did. This is yet another warning that people may give permission for DNR orders on themselves or on other people without having the slightest idea of the awful ways in which this will be interpreted and applied.

*Aside from the better-known medical practices of "no code," and "code blue" (which calls for urgent and immediate attention), there is also such a thing as a "slow or no code," which means that there is no official instruction that resuscitation should not be undertaken, but the intent is that when an emergency occurs, the staff either respond very slowly or put on a superficial "show" to convey the impression that a resuscitation attempt is being made, as by fumbling around feigning inability to find necessary equipment, so as to increase the likelihood that the person will actually die (National Public Radio report reviewed in Colorado Lifewatch, 7/95).

*Colorado Lifewatch (2/95) reported a case where a whole gang of hospital and medical people badgered a family for 3 hours straight to sign a DNR order on their child. The parents said that they eventually simply got worn out and signed it, feeling that they might never get out of the room if they did not. It then turned out that their son was given lethal doses of drugs because he was on a DNR. Just in the nick of time they managed to rescind the order and get the drugs discontinued, after which the child's condition improved and continued to improve.

*Yet another "euthanasia" milestone was a Massachusetts court ruling that health care providers may deny life-saving treatment to patients against their expressed wishes. In other words, more and more, advance directives, living wills and similar documents turn out to be deathmaking devices. If one opts against treatment in one's living will, one is made dead, and if one does not opt against treatment, one's living will is simply overruled (NRLN, 18/7/95).

*One can now buy a necklace or bracelet that says in bold red letters, "Stop--Do Not Resuscitate." It is meant primarily for people who are in hospices or nursing homes, or dying at home. Some people have the message tattooed onto their bodies. For instance, a 40-year-old nurse had her "living will" tattooed onto her stomach in red and black (AP in Indianapolis Star, 22/1/95; source item from Joe Osburn). However, ambulance and emergency crews have said that they are not bound by these messages (SHJ, 15/5/97).

*At the VA hospital in Syracuse, right outside the chapel, there is as of early 1998 a pile of give-away forms of the "signing-your-life-away" type, de facto being pushed by the chaplains at the hospital (source item from Jim McAskill).

*There is a scheme that enlists people to buy living wills in bulk very cheap, and then sell them to others one at a time, a bit like selling cosmetics out of your home (source material from Karen Barker).

*The phoniness and deceptiveness of the advance directive culture was underlined by a finding that during times of acute hospitalization, only 26% of advance directives were recognized of those people who had filled one out upon their hospital admission and later did not have their mental faculties functional. Apparently, in most circumstances, the advance directive simply was not accessible and knowable to the medical personnel on the scene (Communiqué, 20/10/95). Another study (One Step Ahead, 8/97) found that the treatment decisions desired by people in the end stage of fatal diseases were commonly ignored. More than half the patients wanted life-sustaining treatments even if there was little chance of success, but only about half of these actually received them. Conversely, of those who did not want such treatments, more than half received them anyway. In most instances, physicians made the ultimate decisions regardless of the patient's

desires. This is just one more bit of evidence of the phoniness of the advanced directive, "choice" and "self-determination" culture.

*One of the ways advance directives are biased toward death is that to refuse treatment, one may only have to check a box on a form, but in order to opt for treatment, one may have to start writing out paragraphs.

*The most recent edition of the American Medical Association Code of Medical Ethics says that physicians do not have to give treatments requested by patients in their advance directives, and the American Thoracic Society has been even more explicit in declaring that life supports can be withheld without the consent of the patient, or of a surrogate, if the physician judges it as "futile." So far, the courts have upheld this (NRLN, 7 Sept. 95).

*Advanced Choice is a new vulturing organization which, for a fee of $20 per year, will accept a deposit of one's living will (and/or health care powers-of-attorney) and promises to make it available within minutes and around the clock when a physician or hospital "needs" it. The sales pitch is that in 74% of cases when it is "needed," it is not at the fingertips of those who want it (Source material from Margaret W. Sager).

*A hospital in Scotland starved a comatose woman to death. Her husband (a butcher) refused to be with her when she died, staying home watching television instead. He said that as far as he was concerned, his wife had died years ago and he was done grieving (source item from Peter Ritchie).

*Significant coincidences abound. The Butcher parents in Minnesota got a court ruling permitting food and water to be withheld from their comatose son, over the objections of an advocacy group for "disabled" people. The parents' lawyer said that "it's nice to have these folks out of the way," referring to the impaired advocates (AP in SHJ, 18/10/94).

*Japan has finally caught up with Western modernism, passing a law that redefines death so that organs could be "harvested" from people who traditionally would have been viewed as still alive (AP in SHJ, 18/6/97).

*A research study purported to find that "terminally ill" people should not be given food and water if they do not want it because it heightens their discomfort, and that starving seems to ease their deaths because dehydration lessens consciousness, diminishes pain and promotes sleepiness. This was widely reported in US media, which of course are pro-death. This study appears to be a bit of deathmaking propaganda based on a kernel of truth. We conferred with several experts (whom we thank) on terminal illness, and can report the following.

1. It is usually only when people are within days or a very few weeks of death that they may want to quit altogether to eat or drink, or find eating and drinking onerous.
2. Yet people may be defined as "terminally ill" years before they die, or when they begin to receive a hospice service and are expected to die within 6 months.
3. Dehydration and starvation should never be linked together because these result in very different ways of dying.
4. Sometimes, loss of appetite is secondary to being depressed, and can be stimulated by meeting a person's physical, emotional and spiritual needs.
5. Pain can be diminished by means other than starvation or dehydration.
6. A very critical issue is whether the body is incapable of processing either nourishment or liquids, which sometimes happens, but usually only when one is very near death, not months before. For instance, if the kidneys shut down, administering fluids could even make things worse.
7. If a person is truly within days of death, the person is extremely unlikely to die from starvation because it will usually take a week or more to dehydrate to death unless one is in very poor shape already, and it will take even longer to starve to death.

Other Instances of Dangerousness in Hospitals

*We have long taught about the danger of being in a modern hospital, particularly for already vulnerable and devalued people. In fact, the TI has published a monograph on how to protect people from injury and death while they are in a hospital (see further below). Lately, research has shown that the problem has been getting worse, and that 2 million Americans will suffer some kind of injury from their stay in a hospital every year, and that 90,000 die every year from hospital-acquired infections alone (SHJ, 12 March 98).

*The Australian federal health department said that about 70,000 patients a year in Australian hospitals suffer health injuries (which it euphemistically calls "complications") due to human error or health system flaws. Of the 305,000 patients who come to hospitals because of accidents rather than disease, an astonishing 44,111 suffered some form of "misadventure" during medical care, and 11,062 had adverse drug reactions. Even where genuine negligence was involved, which is much less often the case than other kinds of failures, only somewhere between 4-10% ended up in court, and more than half of these cases failed. Even the ones that won ended up with only about 59% of the compensation that they had gotten awarded (Adelaide Advertiser, 18/2/92).

*An extensive study of hospital care in both Massachusetts and the US as a whole, called the Harvard Medical Practice Study, has published its results in bits and pieces (a lot of it in the Journal of the American Medical Association), mostly since early 1990. Concurrently, a large study of hospital medicine in New York State was published in bits and pieces in the New England Journal of Medicine, and the results were extrapolated to the broader hospital scene. The Harvard study reported that mistakes by hospital personnel result in 100,000 hospital deaths a year, and that many of the mistakes go either unknown, unrecognized, unreported or uninvestigated. Some critics claim that these numbers are very much on the low side. In addition, some 1.3 million patients were estimated to suffer some kind of injury while in hospitals. The Harvard study also found that the privately-insured patients got much better care, from diagnosis to treatment. Also, uninsured patients had death rates three times higher than insured ones, to some degree due to the fact that they waited too long before coming for help. Unfortunately, the larger Harvard study was based on 1984 data, and the smaller study on 1985 data. Mostly likely, this means that the problems reported have gotten bigger, not smaller. How incredible these results are even to news reporters was underlined by a newspaper article from Maturity News Service in the Syracuse Herald Journal (22/3/92). The article reported the data on 100,000 hospital deaths a year, but the headline said "Study Says Hospital Error Kills 1,000 Patients Yearly"! They could believe a 1,000, but not a 100,000, and therefore made a Freudian slip.

*During a 5-year period, there were over 660 "unexpected deaths" in Colorado hospitals. Only in some could it be shown that an obvious error had been made (usually one of surgery or drugs) that presumedly caused the death (SHA, 10 Sept. 95).

*The inspector general of US veterans hospitals issued a damning report about one in North Chicago, where "errors" led to a series of deaths (AP, in SHJ, 24/4/91). "Errors" often are not errors at all, but the end point events where things are systemically very wrong.

*A woman physician serving a residency to become a pediatrician was instructed to treat a boy who had Down's syndrome by injecting one drug intravenously and another one into the boy's spinal canal. Instead, she injected the drug meant to be used intravenously into the spinal canal, which was known to be fatal according to well-known drug guidelines. Heroic efforts to save the boy failed. An investigation was not able to determine why the resident had injected the wrong drug since everything else seemed to be in order. Fatigue was also ruled out as a relevant factor. Furthermore, the resident was said to have been one of the better ones at the hospital. Cases like that may be due simply to probabilistic human errors which are bound to occur a certain number of times, but one also cannot help wondering whether unconscious devaluations or even death wishes

may be at work when a patient victim is a member of a devalued class, and particularly the kind of class that many physicians believe ought to be dead. We need to be very clear that deadly errors can be made by people who hold such attitudes without them consciously intending to inflict injury, and without being aware of how their values and emotions act upon them to bring about unconscious errors.

*When a US veteran in a hospital is expected to die soon, hospitals may then precipitously dump that veteran on the doorstep of the nearest Veterans Administration Hospital. Almost 20% of the patients who were thusly dumped died within hours, and almost certainly sooner than they would have done otherwise, because of the trauma of being moved around while in very critical condition (IAETF Update, 7&8/93). The motive for this is to reduce the deaths on one's records, because it would not make one look good.

*Rates for hysterectomy operations have been declining in recent years across the industrialized world, except in selected locales. Critics charged that this has little to do with risk factors but is the result mostly of medical promotion of the operation. Almost every effort to pass laws requiring that women contemplating an abortion be told of either its risks or the alternatives has been struck down in the courts, and yet there has been relatively little outcry against efforts to pass laws that would require physicians to furnish women faced with a possible hysterectomy with detailed information on the procedure and possible alternatives.

*An investigation into hospital practices found that poor people got inferior care compared to other patients. For instance, they get inferior information and instruction about necessary health regimens (AP in SHJ, 19/10/93).

*Brook, I. (1995). Anaerobic infections in children with neurological impairments. American Journal on Mental Retadation, 99, 579-594. In our teaching on the sanctity of life, we have urgently pointed out that the installing of both nasal and gastric feeding tubes incurs a great many health risks, and that gastric tubes particularly are a slippery slope to death because of all the complications that attend them. However, most people are not told this, and gastric tubes are often installed merely for management convenience and to save money by not having to pay personnel to feed people. For people who had not known this or are skeptical about it, we recommend that they read Brook.

*While we are generally amused by computer sabotage in that it shows up the idolatries of our age, we were appalled to learn that a computer hacker in India gained entry into a hospital computer control system in France, which altered the setting on patient alarms and caused the deaths of 2 people (Speak Out, 4/90).

*It is a very sad commentary that only after a 69-year-old man in a hospital put a copy of Final Exit on his bedside table did he immediately receive better treatment (Time, 9 Dec. 91).

*Here is a new phenomenon: patients in hospitals who are de facto forgotten or abandoned by harried nursing personnel have begun to call 911 from their bedside phones, which usually works, at least until one's phone is taken away (CBS "60 Minutes," 1 Aug. 95).

*In 1987, the TIPS editor published a 20-page "Guideline for Protecting the Health & Lives of Patients in Hospitals" as an appendix to the first edition of The New Genocide of Handicapped & Afflicted People. Then, in 1992, The New Genocide was slightly revised and reprinted, and the "Guidelines" were greatly expanded and published as a separate 80-page monograph, with the same title. Since then, we have strongly encouraged anyone who is concerned about the welfare of hospitalized persons to read and apply the guidelines (available from the TIPS address for $6.50 per copy, plus shipping and handling).

We recently received a letter from one mother of a young woman with Down's syndrome, which dramatically validated some of the advice in the Guideline. She reported that a recent hospitalization of her handicapped teen-age daughter went well because of the following things.

1. The daughter was in a double room in which one patient bed was empty, so her parents used the other bed to rest, and to enable one of them to be with her constantly.
2. Family friends, her brother and sister, and her school friends stopped by daily.
3. Cards and flowers from teachers and teachers' aides, and family friends arrived daily.
4. It being the Christmas season, her father made and hung hand-crafted Christmas decorations in the room and above her bed.
5. The nurse in charge of the daughter's care was the mother of the daughter's brother's best friend.

When she left the hospital, she gave away most of the hand-crafted Christmas decorations to those hospital personnel who had helped her.

All in all, it sounds like the family served the hospital notice from the very beginning that this young woman was highly valued, and that her family and friends made great efforts--and probably much sacrifice too--to insure that not only did she not get made dead, but that she was well-treated. One result was that her attending physician became very attentive, and continued to be so after her hospital release.

Deathmaking Service Agencies

*During the 1980s, a new kind of de facto institution developed, sometimes called a pediatric hospital. It is for children who are not expected to live long, but these facilities actually function as dead-making centers.

*According to a 3 April 1996 report on ABC-TV's "Primetime Live," an estimated 6,000 severely handicapped children in the US are institutionalized in nursing homes at any one time, often because Medicaid will only pay for that kind of care, and not for care of such children at home or in small community residences. Here are seven problems with such placements that were uncovered by this report.

1. The children are juxtaposed to old people, and people imaged as dying--what the reporter referred to as "living side-by-side with geriatrics."
2. There tends to be a low level of staffing for children with a high level of need, resulting in very poor treatment. For instance, it takes about ½-hour to feed each child, yet in one setting, a single nurses' aide was in charge of 17 children. Also, as a result of staff shortages (and for staff convenience), many children are put on feeding tubes and may remain on them for life.
3. In part because of staff shortages, but in part for other reasons as well, staff do not respond to children when they should. For instance, children are left lined up in hallways for hours at a time, often crying for more than an hour. One child was left to sit in her vomit for more than an hour. Alarms on feeding machines and even breathing machines can sometimes sound for more than an hour, yet no staff respond. One girl who needed a machine to breathe was on the phone with her aunt when her machine malfunctioned and its alarm rang. No staff responded, so the aunt had to run out of her house to a corner store to telephone the nursing home and tell them to attend immediately to her niece's breathing emergency.
4. Children were kept in cage-like cribs that one used to see in the mental retardation institutions of the 1960s.
5. Some children have DNR orders, but staff do not necessarily know which ones, so they may let a child die who did not have a DNR order.
6. The nursing homes may not have enough supplies or equipment. Nurses have paid for soap and baby formula out of their own pockets. But much more serious is that there is not enough resuscitation equipment. In one instance, there was only one airbag when two children went into pulmonary crises. Staff decided on the spot which child to try to save and which to let die; in the end, both died. Said the mother of the child who had not been treated, "She was my daughter--not my mentally retarded daughter, not my daughter with cerebral palsy, but my daughter."

7. Rough handling by staff has broken children's bones.

In one Texas nursing home alone, 12 children died in an 11-month period, and the state found that all these deaths were due to a lack of care and/or training by staff. Obviously, these kinds of facilities are deathmaking machines. This is underlined by the fact that their number has kept increasing despite their high death rates.

*Investigations in 1991 revealed an entire series of suspicious deaths at homes for severely impaired children in the Canadian province of Ontario. In one such private home for about 30 children funded by the provincial government, there were 30 suspicious deaths over a 4-year period.

In early 1992, there was an inquest about the deaths of 15 of the children (12 supposedly of pneumonia) in a relatively small home for medically fragile children (the Christopher Robin Home, which calls itself a "residential developmental centre") in Ajax, Ontario. Unless a parent specifically brought up the issue and requested otherwise, all children in the home were placed automatically on a "do not resuscitate" order upon admission. Furthermore, the home's care policy was described as "palliative," meaning that when a child got sick, no tests would be done and no treatments sought. In fact, even worse than that, children would be put on massive doses of morphine which would accelerate their deaths, as had happened in 15 cases. First of all, morphine would ordinarily only be administered against pain, which did not appear to be the reason it was administered here. Secondly, in at least some instances, the morphine was administered in doses 2-5 times higher than it would have been had there been pain. Apparently, one of the things that brought the issue to a head was that one of the children who was made dead with morphine was the granddaughter of a former Premier of the province of Ontario.

One of the unusual elements in this case is that People First (made up of retarded people) of Ontario was granted legal standing in the case, and was represented by an attorney in an inquiry by Ontario's chief coroner. (Source items from Don Weitz & Beth French).

Teams of participants at PASSING workshops have done practicum assessments at a number of homes similar to the one described above, and have commonly interpreted them to be deathmaking centers where the world, and sometimes parents, get rid of handicapped children. Often, the children are not really that handicapped or medically fragile, but are interpreted to be, just so they can be put in such a place and made dead.

Deathmaking In/By Medical Emergency Services

People are generally not aware what a great role in deathmaking emergency services have become, including ambulance services. Instead, people think of these as rapid life-savers.

*Deaths related to emergency service practices in the US these days include those in the category of "patient dumping," i.e., when people are not admitted to a near-by emergency service but are sent somewhere else (e.g., to a public hospital) for financial reasons, and as a result suffer damage or die. In an 18-month period overlapping 1995-96, 256 US hospitals were found to be engaged in such dumping (e.g., Health, 1/98).

*In 5/98, a 15-year-old boy was shot while playing basketball 100 yards from a Chicago hospital. His friends brought him to the hospital's emergency service, but he was denied admittance. Some of the hospital workers were standing around outside smoking while the boy was lying there. A police officer who happened to be near was incredulous, and simply commandeered a wheelchair and brought the boy in, but it was too late, and the boy died 30 minutes later. Wait for the lawsuit to follow.

*It would appear to us that when ambulance attendants steal credit cards and cash from the wallets of ambulance patients (which is apparently not an uncommon occurrence), they are capable of making the patients dead as well. Allies of patients being taken somewhere in an ambulance should always collect the patient's valuables first, including jewelry, for safe keeping.

Dangerousness in Nursing Homes & Similar Settings

*There are 17,000 nursing homes in the US, with 1.6 million residents (Time, 3 Aug. 98). However, very few people who enter nursing homes live more than five years (Health Letter, 11&12/91). This speaks not only to the debilitated condition in which some people may enter, but also to the fact that living in a nursing home has a powerful deathmaking impact on people.

*More than half the suspicious deaths in Calif. nursing homes are believed to be due to neglect, and almost a third of Calif. nursing homes have been cited for "life-threatening" problems. The situation is said to be about the same all over the US, despite the federal government paying $28 billion to nursing homes in 1997, and collecting only $518,000 in fines (about 20% of the fines levied) for noncompliance with standards. In fact, 20,000 nursing home residents are estimated to die prematurely, or in unnecessary pain, or both (Time, 3 Aug. 98).

*About 58% of elderly people in nursing homes suffer from malnutrition (SHA, 19/5/91). As we have pointed out in numerous contexts, a major reason is that in medical settings, it is rare to see a significant investment in mealtime issues, and people who need help in eating hardly ever get any. Often, residents also begin to eat less as a result of other conditions, such as loss of teeth or poorly fitted dentures that are not attended to, or lack of appetite due to unappetizing institutional food. A survey of nursing homes in the US revealed that about 30% of residents are so underweight as to risk premature death. Even the highest-ranked nursing homes have a relatively high rate of underweight residents (AARP Bulletin, 12/97).

*Half of nursing home residents every year have a fall. This rate could be greatly lowered by lowered bed access, wheelchair seat belts, and a perceptually less confusing floor design.

*One incongruity on the current medical scene is that one of the few medical settings in which one may find considerable effort at environmental beautification and cleanliness are nursing homes that have embraced very systematic deathmaking policies, such as even forbidding the staff to apply a Heimlich maneuver to a choking resident, and that therefore have high death rates.

*In a nursing home for the handicapped and elderly run by an order of Catholic nuns and named after one of the popes, 81 out of 120 residents had died within 2 years. This is a 67% mortality rate--despite the fact that the nursing home was only 2 years old, was beautiful both inside and out, had highly trained and committed staff, was well-funded, and had many of the other qualities or characteristics which would enable it to be certified by various accrediting agencies, and might even make it attractive to families looking for a placement for their elderly relative. In this same nursing home, outside one of the dining rooms was a wall-sized mural of the astronauts who died in the Challenger space shuttle explosion--the kind of portrait one would only expect to find in something like the National Aeronautics and Space Administration Museum at the Smithsonian Institution, and certainly a death image juxtaposition. Furthermore, the use of the 3 dining rooms was divided according to the impairment level of the residents. Those who were sociable and capable of eating totally independently were served in a beautiful room with elegantly laid linen tablecloths and flowers. Those who needed a bit more assistance were served in a room that had tablecloths and flowers, but was not quite as nice as the first one, and included long, cafeteria-type tables rather than smaller ones that foster intimacy among the eaters. Those residents who needed total assistance in eating were rushed through their mealtimes in a drab room almost totally barren of any decoration and any amenities on the tables, and which was referred to by the staff as the "feeding room."

*A 500-bed nursing home in Philadelphia was ruled in 6/95 to "constitute an immediate and serious threat" to the health and safety of patients, and told by the city that it must make drastic improvements within two weeks or the city would cut off its funding (Health Letter, 9/95).

*A nurse blew the whistle on the bad conditions at a nursing home in Denver which, among other things, had resulted in three deaths, but the facility was neither fined nor reprimanded by the state even though state investigators confirmed what the nurse had said. The nursing home promised to make improvements, and the one prominently featured in the newspaper was an "ice cream parlor" being installed in it (Denver Post, 9 July 92; source item from Thomas Neuville).

*A large California nursing home chain was charged with hundreds of health-care violations, including some awful ones such as letting people lay in their excrement, and patients being found with maggots in their sores. In the perverse logic of our day, a lot of people conclude that this sort of thing is one more reason why we need "euthanasia" (IAETF, 8/90).

*A resident of a nursing home overheard nurses talk about the fact that they were terribly overworked, and that some of the feebler patients simply had to die in order to give them some relief.

*One mutual disablement cycle occurred when elderly people in nursing homes would totter about, fall, break something, and their attorneys would then sue for damages. Among other things, this contributed to a massive increase in restraints in nursing homes. On a given day in 1991, an estimated 500,000 people in hospitals and nursing homes were tied to beds or chairs. This led to many deaths, as when people slipped and suffocated. In turn, in the late 1980s this led to a massive attack on such restraints by advocacy parties. One nursing home official said that "if there were less lawyers, there would be less restraints"; and at a 1989 Washington symposium, entitled "Untie the Elderly," one nursing home official suggested that the subtitle should have been, "Tie Up Their Attorneys" (NY Times, 28/12/89). But then on the third hand, the restraints themselves have also been a fertile source of lawsuits, because people get hurt or even die, as by strangling in their restraints, with lawyers not far behind winning zillion-dollar suits.

We are not among those radicals who demand that debilitated people should never be restrained. In fact, applying a restraint can sometimes enable other positive options, e.g., getting someone up or into a wheelchair, and thus moved to events or into the open. However, there are many problems with the way restraints are used in nursing homes, often for no more than management convenience or staff shortage. In US nursing homes, federal regulations forbid tying up residents for purposes of "discipline or convenience" rather than for purposes of treatment of medical symptoms, for whatever that is worth.

*For many years now, US nursing homes have been employing many people with criminal records. The issue keeps coming up, and none of the measures taken so far seem to have been effective.

*Despite a long history of abuses in nursing homes, 3/92 marked the first time that a Texas nursing home company and 8 of its employees were indicted by a grand jury on felony charges in the deaths of patients. Readers should keep in mind that it is a long uncertain way from indictment to conviction; and even when people get convicted of deathmaking, they often get off very lightly.

*It is not only the staff who may abuse nursing home residents. At one such facility near NY City, 10 of the most vulnerable residents got physically and sexually abused by other residents (AP, in SHJ, 28/8/95).

*Bad nursing home conditions contribute not only directly to death rates, but also indirectly, in that they fuel the arguments of deathmakers that people would be better off dead than in nursing homes.

*This fall (1998) started the nth round of US congressional hearings on nursing home abuses. These rounds started in the early 1970s. One such wave of investigations, warnings and hearings took place in 1990, making national news. Charges included that abuse was on the increase and

reporting of abuse on the decline. People concerned with nursing homes seemed to be taking abuse more for granted, to have become desensitized, or to be simply giving up. Each round is (a) treated as if it were the first, and (b) ended as if a solution had been arrived at.

*Surprisingly, in early 1995, the Wall Street Journal published an article by a woman who, despite the usual kinds of death-talkings and medical intimidation, took her mother out of a nursing home and took care of her at home even though she required a great deal of nursing and medical support. The writer said that instead of talking of mercy killing, we should begin talking of mercy living.

Danger to Life From Home Care Services

*Good help is hard to find these days, and that is very much true in regard to personal care attendants for handicapped people. Increasingly, one hears all sorts of horror stories of what such helpers do to people they work for.

*A 57-year-old woman with a history of heart disease and a breathing tube down her throat was being tended to by the aides of a home health aide company in the Syracuse area. One day, the tube got clogged and the woman started choking--but this was at the end of a shift of one of the aides who simply deserted her when her replacement failed to show up on time. When the replacement aide finally came, she found the woman in critical condition, and too late. The woman died the next day (SHJ, 21/10/92).

*In 1992, a paid caretaker in Washington State got into an argument with her charge, a paralyzed man, with whom she had developed a romantic relationship, and asphyxiated him with a pillow case.

*In Seattle, a man paralyzed from the neck down threatened to report his caretaker for mistreatment. Because she did not want that to happen, she suffocated the man with a pillow and then fled to Canada in the handicapped man's van (Seattle Times, 1 July 92; source item from Marilee Fosbre).

*One just never knows who the home health agencies will send to one. A male home health aide in Syracuse raped and murdered a woman he had been assigned to take care of, and when arrested, he was found to have been a serial rapist (SHJ, 14/4/97). The trouble is that he may be out of prison in five years or even less.

Deathmaking in "Hospice" Contexts, & Other "Hospice" News

*In the US, the "hospice" business has become very big, with many vested interests, caring for 450,000 people each year in over 3,000 settings, for a median length of 36 days. However, it is difficult to say what "hospices" do because the term is used so loosely.

*Elsewhere, we have noted some of the problems with contemporary "hospice" services for people said to be "dying," the most problematic of these being that such services are apt to be either seduced into, or are willing to join in, various forms of deathmaking of "dying" people, such as casting a "dying role" expectancy onto people, and not offering treatments that could easily be given and that would be given to anyone not seen to be "dying." Of course, none of this is to deny the good that "hospice" services may also do, and that for very many dying people and their families, such services do provide an alternative to dying in a hospital.

However, in addition to the above problems and others that we have noted earlier, we have also begun to become aware that many people are investing "hospice" services with expectations and meanings which other people, and perhaps earlier generations, would have attributed to intimate communities and communalities, such as church and family. Thus, "hospice" services are beginning

to move--in our opinion, very problematically--into a vacuum that has been created both by decommunitization, and by the rejection and abandonment of religion. For instance, one of the things that "hospice" services offer is help at home for the family of a dying person--the kind of thing that family members and members of church congregations used to do for each other. Also, "hospice" services provide people to sit with a dying person while their family members work at jobs, run errands or attend to other business--again, the kind of thing that family members and church congregations used to do. As well, "hospice" service staff are willing to talk with people about death, and recruit pastoral care for them--and this is one of the things that especially the churches used to do, and do well. Now, people either no longer want to hear what the churches have to say about dying, and/or the churches no longer talk about death, and certainly not with the kind of authority and conviction that they used to.

We have to recognize that even if a "hospice" service has not embraced deliberate deathmaking, it is still apt to be beset by many problems because of the contemporary values and service context in which it occurs, and some of these can be de facto contributory to deathmaking. Below, we list four such problems.

1. At least in the US, funding for "hospice" services may only last six months. This creates a strong role expectancy message to the "dying" patient to get their dying over with before six months is up, lest they outlive their funding. It also creates incentives to "hospice" personnel to do things that insure that the person is dead within six months, lest their funding run out, and lest this raise suspicion that the person is not "dying" at all.

2. At least in the US, public-paid programs such as Medicaid are happy to pay for "hospice" services because these cost less than the more expensive higher-technology services such as hospitalization entails. Also, once the patient is dead, it costs Medicaid nothing at all. The problem is that this may create an incentive to classify a patient as "hospice"-eligible, and to thereby get or keep the person off higher-tech and more expensive services from which the person might benefit.

3. "Hospice" programs can sometimes be adamant that once they enter into a "dying" person's life, the patient and/or the family have to pledge not to seek active treatments. This includes exerting very strong pressure for the patient or his/her empowered surrogates to sign DNR (do not resuscitate) orders. If a person receiving "hospice" services develops any sort of complications that ordinarily might warrant hospital admission, and the person actually does go to the hospital, then the "hospice" service and its servers may withdraw, and not serve the person again. For instance, "hospice" services may not "allow" emergency services (e.g., 911 numbers) to be called if one wants the "hospice" servers to come to, or stay with, a patient. In fact, even relatively simple measures such as IVs may not be permitted, though exceptions may be made. Obviously, measures like these also constitute a strong incentive to see a person end up dead sooner rather than have more expensive and high-tech services used, and possibly even mean that a person could die from dehydration if the person is not given liquids by IV that the person could have ingested.

4. The "hospice" culture prides itself on being able to generate and administer drug regimens so that patients will not feel pain. The problem is that so often, this gets perverted into premature and excessive drugging of people not only with painkillers but also with tranquilizers, so that they drift rather mindlessly and unconsciously toward their death. In other words, drugs can be administered prematurely and excessively by "hospice" people because their minds are so intensely oriented to making a person's last months painless.

We can see that altogether, it has indeed proven most difficult for "hospice" services to tread a middle course between their early ideals, and complicity in at least some forms of deathmaking, so that they find it difficult to even individualize their rules and provisions, lest the entire model collapse.

*We were told in early 1991 about an elderly man with cerebral palsy, who had a disease diagnosed as terminal but who was not in an acute medical condition, and lived in a supported apartment. A newspaper article had appeared about him in which he explained his desire to live out his remaining time at his home rather than in a hospital. When he came down a few months later with an unrelated condition that required him to be hospitalized, the "hospice" people were there and

"swarming all over," even though his condition was such that he could be expected to recover and return home. Presumably, they had read about him in the newspaper, found out he had been hospitalized, and assumed that they were needed! Further, the "hospice" people primarily occupied themselves with talking with and to the staff of the residence where he lived, rather than to him, presumably about their coming to grips with his illness and impending death. At least part of this must come from the fact that most people would find it easier to identify with the staff than with him, and that they would therefore prefer to talk with staff than with the afflicted person. Also, there appears to be a presumption that everyone needs expert counseling in order to reconcile themselves with suffering, illness and death, even though that may not be the case.

*One of the things that is wrong with a great many so-called "hospice" services for "dying" people these days is that they have a totally inflexible ideology that has no room for individualization. For example, they may refuse to participate in the administration of an antibiotic even in those instances where there is a good chance that it would be effective and prolong the life of a person who wants to live a bit longer, and who perhaps still has something that he or she wants to do. One almost gets the impression that these services will only make themselves available to people who actually want to die rather than to those who face up realistically to the imminence of death, but do not have a death wish. A striking example we know of is that of a young man with terminal cancer who asked a long-time woman friend to marry him, and she agreed even though she knew that he might only have a few more weeks to live. Shortly after they got married, a "hospice" offered to serve him but would not do so if he accepted non-heroic treatments such as antibiotics, even though this might extend his brief married life by a few days or weeks. This just underlines how difficult it is for a service for "dying" people these days to maintain a moral middle path.

*A free-lance writer whose mother died in a "hospice" wrote a sympathetic critique of the "hospice" culture, in which she observed that despite their best intentions, some hospices "end up bullying patients who won't pass away gracefully" (Health, 6/91).

*That "hospice" services have been moving toward becoming yet another deathmaking mechanism was confirmed in the 1995 book by L. Shavelson, A Chosen Death, that included a number of vignettes of "hospice" services providing suicide assistance.

*On 11/19/90, the National Hospice Organization of the US formally approved of a "patient's right to refuse..artificially supplied hydration and nutrition." It also defined "hospice" care rather peculiarly as "an alternative to voluntary euthanasia and assisted suicide," which is a bit like resolving that sending the Jews to Palestine is an alternative to gassing them. Thankfully, the organization also went on record to "reject the practice of voluntary euthanasia and assisted suicide in the care of the terminally ill." However, we repeat that services to "dying" people are strongly vulnerable to serving deathmaking purposes, even if unconsciously so. Generally, at major "hospice" conferences, advocacy on behalf of living wills, assisted suicides, and "euthanasia" has found a forum, and opposition to such measures is beginning to fade away (IAETF Update, 9&10/91).

*The American Hospice Association as a whole entered an amicus curiae brief in the 1990 Nancy Cruzan case in favor of withdrawal of her nourishment and liquids. One of the bizarre aspects of this incident was that Cruzan did not qualify for "hospice" care because she was not terminally ill or "dying."

*Leaders in the palliative care movement are predicting that the "euthanasia" lobby will hijack the term "palliative care" as a euphemism of what happens when people are denied medical and life supports even though they are not terminally ill.

*The US Department of Health and Human Services has been complaining that people in "hospice" programs are not dying fast enough, and they have been threatening "hospice" programs

that they may have to pay back any funding they got for patients who did not die in the 6 months that is allocated to "dying" people to die in. One of the people who outlived her 6 months said, "I just feel terrible because I cause the hospice trouble. I would die if I could but God won't take me." Actually, only 10% of "hospice" patients outlive their allocated 6 months, which suggests that the 6-month prediction about the "hospice" population overall is remarkably accurate (Fingerlakes Times, 16/3/97; source item from Jim McAskill).

*When people enter a "hospice" service, they are usually expected to surrender all claims to medical treatments other than comfort care. A woman in Colorado felt that even though she was dying of cancer, she could benefit from a certain medical treatment, but when she requested to be released from the "hospice" service, a powerful tranquilizer was administered to her instead, plus a continuous morphine drip which of course can be quite deadly. Sure enough, she was beginning to drift into a coma. In essence, she was being killed with morphine instead of dying from cancer. She also developed a massive bedsore. All this was done on the basis of a living will she had once signed earlier. Her brother liberated her from this deathmaking setting, upon which she made a remarkable recovery to consciousness and vitality. The deathmakers then went to court to enforce the original living will even though in the meantime, she had unequivocally repudiated it. It became clear that the containment of medical costs was a major motive of the deathmakers. She eventually died from the cancer, several months after the 6-month deadline one is normatively given in US hospice services (Denver Catholic Register, 2 Oct. 96; source item from Marcia Tewell).

*One of the many dangers with so-called "hospice" care was revealed in Denver. There, an insurance company refused to pay for the care of a woman in a hospital after her guardian had her transferred there from a "hospice" because she was getting such bad care there that she developed severe bedsores--this despite the fact that the woman had plenty of insurance coverage, at least on paper (Colorado Lifewatch, 9/96).

*An agency called Hospice of Central New York held a conference in 10/97 on "physician-assisted suicide" which was chaired by an academic who had written a text in support of deathmaking, and at which euthanasist physician Timothy Quill was a major speaker. This exemplified the kind of fear that we expressed a long time ago that because of the cultural context, the "hospice" movement in the US has to be expected to eventually succumb substantially to deathmaking ideologies--a prediction which has been hotly contested by many people who have had positive experiences with "hospice" services.

Also, in another context, a Syracuse physician said that the only reasons he did not help his patients commit suicide is that "it is illegal and I don't want to go to jail. And because I work for hospice and the hospice movement disapproves." So instead, he suggested to a patient who wanted to die that he should simply quit eating because that is what other people were doing who no longer wanted to live. Here once again we have the very problem that we have pointed to for many years, namely that the "hospice" movement is not immune to what goes on in its larger culture (Syracuse Herald-Journal, 17/3/97, p. A5), and that we must not be surprised to encounter deathmakers being employed by "hospices," and deathmaking being transacted in that field.

*The "nursing home-ification" of the "hospice" construct was dramatically underlined by the practice of one "hospice" accepting children who were very impaired, and perhaps had degenerative diseases, but who were certainly not moribund. Children may then live for years and years in such facilities. In one such "hospice" (the San Diego Hospice for Children and Adults), a youth had been living 11 years by 1989. Quite possibly, when such children do die, they may do so as a result of multiple dying role expectancies with their attending manifestations.

*An Australian Minister for Health launched "palliative care and hospice awareness week" in 1990 at a dinner in Canberra where raffle prizes were drawn, and one of the honored guests won a "haircut with the works" at the Curl Up and Dye Salon (Canberra Times, 3 Oct 90; source item from Michael Steer).

*We recently learned that some "hospices" have become people's "favorite charities," and that some have been given so much money that they have huge endowments and have ceased fund-raising.

*Ley, D. C. H., & Van Bommel, H. (1994). The heart of hospice. Toronto: NC Press. This is a recommendable book on palliative care, including care at home.

Dangerousness in Multiple Health Care Contexts

*Taking into consideration only developed nations, there is a strong correlation between the ratio of physicians to population and infant mortality. In other words, a quantitative increase in the percentage of physicians cannot be assumed to bring about an increase in health indices, and may even be associated with a decrease in health, though it is arguable whether it causes a decrease (Terrell, 1989). However, to literally add injury to insult, studies have actually found that many high-technology medical procedures, particularly those performed ordinarily only in hospitals, actually increase injury and mortality rates (Terrell, 1989).

*In 3/90, the Public Citizen Health Research Group (a Nader offshoot) filed suit against the manufacturers (Shiley, & Pfizer) of a heart valve, claiming that they had produced about 80,000 defective and potentially lethal heart valves that had been implanted into heart patients. The allegations go back as far as 1984 when the problem was drawn to the attention of the manufacturers who refused a voluntary recall until 11/86. Several hundred people died as a result of the valve defects, and the others faced the prospect of yet another chest operation to have the valves replaced (Health Letter, 5/90).

*Certain deathmaking dynamics commonly come into play when a patient is elderly and debilitated. Members of our culture are then tempted to interpret that person as someone who would really be better off dead, or that it would be better for society if the person were dead. One may then observe a certain indifference from nursing personnel toward such a patient, in regard to fairly basic aspects of care, and possibly a progressive withdrawal of nursing presence. For instance, such patients may receive inadequate attention to pressure sores and eventually outright bedsores, and even those methods which would counteract bedsores with good home nursing care may not be forthcoming in a hospital. One study found that even without any explicated policy or rationing strategy, elderly people are being discriminated against by not being offered the same kinds of medical treatments for certain conditions (such as cancer) as are younger patients, even when the elderly person is in good physical condition (Life At Risk, 7/92). Thus, more and more, the elderly are seen as candidates for "aid in dying," but poor prospects for "curative therapy."

*A survey of the mortality of 100,000 people with "developmental disabilities" during the mid-1980s revealed that those who were nourished by tube had short life expectancies of only 4 to 5 years. Being fed by others doubled life expectancy to 8 years. Death rates were also very high among those who could not move about, while even non-ambulatory mobility gave them an additional 23 years of life expectancy.

Health Maintenance & Managed Care Organizations as a Major Deathmaking Force

So-called health maintenance organizations (HMOs , specializing in so-called "managed care"), are more and more becoming deathmaking machines. Here are some of the ways they work like this. (a) They deny payment for procedures that really are needed by specific individuals (often under the pretense that they are not needed), so that their conditions become worse or even fatal, or their lives are abbreviated if the condition was already fatal when discovered. (b) In emergency situations, precious time may be lost trying to get authorization for a procedure from an HMO, and even once the HMO has been contacted, the authorization for the procedure may be denied. It may take a very forward physician to keep hassling the HMO on behalf of his/her patient to get it to

change its mind. (c) Even otherwise, they may delay treatment authorization, and the patient may die before the case is resolved. How decision-making gets slowed down by managed care is as follows. Before one could go to a specialist, one has to go to one's primary physician; and before this person can approve the specialist, the primary physician has to get approval from the HMO; and if that approval is not forthcoming, one may be on a go-around of meetings, correspondence, phone calls, appeals, and may end up having to bring in a lawyer whom one has to pay oneself in order to receive the care to which one is supposed to be entitled. (d) HMO physicians may be asked to treat conditions they were not trained to treat. (e) Recommendations for additional services that would ordinarily be made by an independent physician might not be given to an HMO patient. That is not the same as denial of care, but comes close to amounting to the same thing. Many HMOs harass the physicians who participate in their plans to the degree where these become reluctant to order procedures that are truly needed rather than being merely of a defensive nature to avoid litigation. This harassment can take the form of threatening to discontinue affiliation with them, or even actually terminating the services of a physician who seems to generate atypically large expenses. Other physicians who observe this and are worried about their livelihood may then knuckle under. (f) It may be claimed that the proposed treatment is unvalidated (which can have some truth to it, but many conventional treatments are also unvalidated, so in this case, the argument is really a fiscal weapon). (g) Procedures may be denied because they "do not make the body function." On these grounds, many HMOs have disallowed reconstructive and cosmetic surgery on infants born with hideous malformations. Some people have entered HMO arrangements without having read the fine print that spelled this out beforehand, or they did not understand what it meant, or thought they would never have such children (Health Letter, 3/98). (h) Some HMOs dump patients that are beginning to run up significant expenses to them. Often, they do this at a very bad time when aggressive treatment and good care are urgently needed. After all, one big way in which these plans make money is by enrolling people who are not (very) sick, who do not make a lot of medical demands, and by denying care to them when they become sick. (i) HMO physicians may not feel free to speak about their HMO and its services, which leaves a patient less well-informed.

It appears that a lot of physicians who formerly would have ended up practicing in institutions are now found within HMOs. (Various sources, including Health Letter, 9/95; for a long litany of HMO atrocities, readers are referred to the 7/98 issue of Mouth.)

A Boston lawyer pointed out that for HMOs, the issue is very simple: early death of actually or potentially debilitated persons saves much money. If HMOs are not legislated out of existence, they may end up masterminding and directing medical killings (Family Practice, 1 June 96; source item from Dr. N. O'Connor).

What is particularly noteworthy is that HMO practices are adding yet one other layer of causes to the already numerous causes of deathmaking of which we know. The trends in managed care are a particular menace to handicapped people, who are increasingly likely to come under the control of such organizations.

It seems to us that we can just about say now that the HMO model of organizing medical services has proven to be a failure, and yet there is great irony in the fact that at the very time when we can begin to say this, all sorts of other services are being converted to the HMO model, largely via so-called managed care.

*HMOs were invented largely in response to the runaway costs of medical care in the US, and everybody was euphoric about how HMOs would solve this problem. Nobody ever seems to learn that crazes and disfunctionalities beget counter-crazes and counter-disfunctionalities which together make things worse than before. When the current HMO craze is over, people will be writing all sorts of interesting histories about it, and nobody will believe that anything like this could possibly have been allowed to ever happen.

*As mentioned, the situation with HMOs has become so serious that some authorities are coming close to recommending that when one goes to an HMO for service, one bring a lawyer along (Newsweek, 23/10/95). This almost reminds us of the many jokes about bringing a lawyer along when making a marriage proposal, or while getting married, or while having sex.

*Two federally sponsored studies showed that many managed care companies are particularly delinquent in what they provide to beneficiaries who are simultaneously handicapped and indigent (APA Monitor, 4/97).

*As one consumer advocate put it, "HMOs are wonderful for people who want to embrace euthanasia" (IAETF Update, 8/97). Or as a NRLN (30/9/97) article put it, "Medicare managed care is better because it kills you." A writer in Mouth (9/96) likened so-called managed care to being told to surrender one's clothes, being given a bar of soap, and being led to the gas chamber. Many other people have commented that HMOs are the optimal arrangement for healthy people.

*A most sinister deathmaking development in the US is that the Joint Commission on Accreditation of Health Care Organizations and the managed care industry have gotten together and begun to require that employees of medical supply companies that deliver health and mobility equipment and supplies to the homes of handicapped persons must (a) wear a mask and glove while making the delivery (which of course images the impaired person as being dangerously contagious, possibly with a deadly disease), (b) report any evidence of physical abuse or malnutrition, and (c) ask the recipients whether they have an advance directive. Obviously, managed care companies have a "vital" interest in seeing to it that costly dependent people die. Mouth (5/98) said that this is a bit like requiring every pizza delivery man to ask every customer whether they have an advance directive.

*This is not the proper occasion to get into Viagra coverage, except to note that while crucial medical treatments are being withheld from patients by HMOs and health insurance firms, Viagra has been getting lavishly approved. But then, health-vulnerable men have been dropping dead like flies from its use, and perhaps that is the ulterior motive.

*To our surprise we learned that some health insurance companies now own hospitals, and therefore have a profound conflict of interest, namely to deny hospital benefits to patients who simultaneously are insured by them and are being treated in hospitals that they own. Such arrangements should be illegal (Colorado Life Watch, 9/96).

*Here is what Time (22/1/96) had to say in a cover story about HMOs. By reimbursing participating physicians in such a fashion that the less service they render the more money they make, and vice versa, managed care corporations have added yet another conflict of interest to those that have existed all along, and this time perhaps a bigger one than the others. Many commentators have noted that managed care has been deadly to patients' trust in physicians, and that on the other hand, "it is robbing physicians of their essential goodness." It has also injected additional secrecy into the doctor-patient interaction, in addition to the kind of arrogant "doctor knows best" attitude that has always tended to prevail. HMO physicians will either not even tell their patients what treatment options are available, or will bad-mouth the effectiveness or research basis of alternatives. On 13/7/98, Time ran another cover story on HMO atrocities.

*CBS "60 Minutes" (1 Oct. 95) also castigated the HMO culture. HMOs have gained the upper hand over doctors (which is amazing!), and can put a doctor who does not go along with them out of business.

*Reader's Digest (7/97) also carried a story of HMO horror stories. It is amazing how stupid the HMO leadership is in not reading the signs of their impending doom. Our guess is that HMOs are over-playing their hand, and that there will be some kind of very severe reaction, perhaps with some other perversion replacing this one. In fact, by 3/97, 1400 laws had been introduced in various US legislatives to regulate HMOs. Also, in 8/98 a Federal Appeals court ruled that at least Medicare patients (mostly elderly people) had a right to an immediate hearing and other protections when an HMO denied any benefits (SHJ, 14/8/98). NY State passed a law in 9/98 that patients could receive an independent review if they thought an HMO claim was being wrongly denied.

*Even though HMOs now control what physicians do, federal law has made it almost impossible to bring a malpractice suit against a managed care company that has caused injury or death because of what treatments it authorized to be given under its insurance policy; and yet, when such injury or death occurs, the HMOs say that the physician is to blame and not their policies (e.g., Newsweek, 9 Dec. 96).

*While telling their doctors what they should and cannot do, HMOs have arrogantly claimed that they cannot be sued for malpractice by their doctors, because HMOs "do not make medical decisions" (SHJ, 18/11/96). In fact, this claim was upheld in court (Newsweek, 27/7/98).

*Physicians in Tucson, Arizona, were asked how managed health care had positively or negatively affected various features of their practice. There were overwhelming votes that managed care had negatively affected many areas, relationships with patients and quality of care being near the top, with very few areas receiving significant positive votes, and even the affordability of health care (which rated the most positive) receiving only a 39% vote (Health Letter, 11/97).

*Investigators for the New York State Department of Health pretended to be Medicaid recipients and attempted to get an appointment for basic medical care from 18 of the largest Medicaid HMOs in New York City, for three types of situations: an annual check-up for an adult, a first prenatal visit for a 4-month pregnant woman, and a routine immunization for an 18-month-old baby. What they got was an "Olympic-class run-around": constantly busy phones, incorrectly-listed phone numbers, member physicians who were no longer accepting new patients, and physicians listed in HMO directories who were no longer members of the plan. Of the obstetricians reached, 69% could not schedule a routine appointment for the pregnant woman, and 40% of the pediatricians could not make an appointment to vaccinate the baby. All-in-all, it was a situation of de facto denial/withdrawal of health care to the poor, such as we have long talked about in our deathmaking coverage and workshops (Health Letter, 1/96).

*Studies found that HMO patients were more likely to receive medical care of dubious effectiveness than fee-for-service (self-paying) ones, and to have an 8% higher chance of dying within the next 100 days, and 9% within the next year (JAMA, 24/9/97).

*Another new way of deathmaking of newborn infants is to force mothers and their babies to leave the hospital after only one day, and health care organizations are even aiming at an 8-hour limit for routine births. This practice (called "drive-by-deliveries") also endangers the health of the new mothers.

The attempt of HMOs to railroad women through childbirth in a one-day or less hospital stay is also a classical example of what we call "mutual disablement." States are beginning to pass special legislation that would guarantee new mothers a minimum of at least two days in the hospital--which would never have happened without the above unconscionable HMO practice.

*According to Newsweek (25/8/97), one is unlikely to ever get the mental service benefits described in one's HMO handbook, but most people will not be aware of how fortunate that is.

*Whenever a new craze breaks out in human services, there are almost invariably people who make a financial killing out of it, or at least a comfortable livelihood for as long as the craze lasts. Sometimes, the benefit to those in the service-providing business can be astronomic, as has begun to be the case in the managed care industry. One Florida HMO milked the state of vast sums, paid its investors a 7,000% return on their investments--and then went bankrupt. A whole new periodical has sprung up entitled Public Sector Managed Care, which was being promoted with the prospect that with "$300 billion in new business at stake, here is the easiest way to discover and profit from managed care opportunities..." (Health Letter, 12/95).

*One bad sign for HMOs is that their stock on Wall Street has been flourishing. In other words, containing health costs cost a great deal of money which goes into profits for investors.

*Unaccredited HMOs have been just as profitable as accredited ones (Newsweek, 10 Feb. 97).

*Managed care is so profitable that in NJ, the Mafia muscled in on them (Amer. Med. News, 9/9/96; source item from Dr. Nancy O'Connor).

*Some of the largest managed care companies were found to be guilty of rampant fraud, and paid hundreds of millions of dollars in fines, though this has been kept fairly quiet. Some such firms have even changed their names to hide their malfeasance (Health Letter, 3/98).

*A peculiar coterie of people have been drifting into administrative positions of HMOs. They seem to be extremely concerned with making a lot of money, and when their pictures are shown, they look very slick. Health Letter (2/96) tells us about one HMO, US Health Care, which paid its chief executive $20 million in a single year. He also held $534 million in company stock. Like many other HMOs, this one also forbade its participating physicians in any way to "undermine the confidence" of people in the corporation--or to divulge that this is a requirement upon them.

*The nine top-earning chief executives of managed health and managed care organizations in the US received between $6.5 and $29 million compensation in 1996 each. Eight of the nine received more than $7 million (Mouth, 7/98). Also, senior medical officers of HMOs can easily earn millions of dollars a year if they are stockholders (Time, 22/1/96).

*Chances are high that the explosive growth period of HMOs has more or less ended, and that HMOs will increasingly try to extract profits by curtailing medical services even more.

*A Nobel Prize-winner said that the HMO system has changed the ancient medical motto of "First, do no harm" to "First, do nothing" (Health Letter, 1997).

*Mouth (5/97) carried a wonderful spoof Q&A column on HMOs. Some of the exchanges were as follows.

Q. What does HMO stand for?

A. This is actually a variation on the phrase, "Hey Moe!" Its roots go back to a concept pioneered by Dr. Moe Howard, who discovered that a patient can be made to forget the pain in his foot if he is poked hard enough in the eye. Modern practice replaces the physical finger poke with hi-tech equivalents such as voice mail and referral slips, but the result is the same.

Q. Do all diagnostic procedures require advance authorization from your HMO?

A. No. Only the ones you need.

Q. I just joined a new HMO. How difficult will it be to choose the doctor I want?

A. Just slightly more difficult than choosing your parents.

Q. What are pre-existing conditions?

A. This is a phrase used by the grammatically challenged when referring to existing conditions. Unfortunately, we appear to be pre-struck with it.

Q. Well, can I get coverage for my pre-existing conditions?

A. Certainly, as long as they don't require any treatment.

Q. What happens if I try alternative forms of treatment?

A. You'll need to find alternative forms of payment.

Q. My pharmacy plan only covers generic drugs, but I need the name-brand. I tried the generic medication, but it gave me a stomach ache. What should I do?

A. Poke yourself in the eye.

Q. What should I do if I get sick while traveling?

A. Try sitting in a different part of the bus.

Q. No, I mean what if I'm away from home and get sick?

A. You really shouldn't do that. It's best to wait until you return home before getting sick.

Q. I think I need a specialist, but my doctor insists he can handle my problem. Can a general practitioner really perform a heart transplant right in his office?

A. Hard to say, but considering that all you're risking is the $10 co-payment, there's no harm in giving him a shot at it.

Q. Will health care be any different in the next century?

A. No, but if you call right now, you might get an appointment by then.

*One wit applied HMO criteria to Schubert's "Unfinished Symphony," and concluded that 11 of the 12 violins could be eliminated, the oboe player should be eliminated because he had nothing to do much of the time, using the 16th notes added nothing to the overall effect and should be rounded off to the nearest 8th note, a horn passage repetition was redundant, and that Schubert should have tried to achieve his desired effect in one movement instead of two, and if he had done so, he would probably have been able to finish the symphony.

*Audiences at the film, "As Good As It Gets," have been bursting into cheers when one of the actors makes a derogatory remark about HMOs (Parade, 22/2/98).

*People being given a hard time by their HMO can call the Consumer Coalition for Quality Health Care at 1-800-720-8090 for help.

Withdrawal of Medical Care From The Poor & Handicapped

Even aside from US HMO practices, there has been a systematic withdrawal of health care from the poor and handicapped in many countries, usually for utilitarian reasons.

*The number of Americans without health insurance has risen to 43.4 million(!) in 1997, up to 16.1% (AP, in SHJ, 26/9/98), which amounts to about 1 in 6 (Health Letter, 3/98). Furthermore, studies have consistently reported that death rates for people without health insurance are higher. One study found that the death rate was triple. Another found that such people die from 12 easily-treated diseases from which most other people no longer die, and that cancer therapies given to rich or insured people are less likely to be given to uninsured people; and not too many years back, it was estimated that 90,000 Americans died prematurely because of this.

*One of the leading "ethicists" in Western Australia has come right out and said that people over 70 should be denied access to higher levels of health care that are available to other citizens. Interestingly, he said that this would be much fairer than discriminating against homosexuals, prisoners, and other devalued groups (West Australian, 28/7/94; source item from Bob Jackson).

*Because the US Medicare system for the elderly and "disabled" pays only about 80% of the medical costs, people who cannot afford the rest and who have no other forms of insurance are turned down by many physicians and medical services (AP, in SHJ, 22/2/93).

*Not only the US federal government, but a number of states as well have systematically withdrawn programs that would pay for the medical care of poor people. One of these was the State of Michigan. One woman on blood pressure medicine began to reduce her medication because of the above reason in order to make it last longer--and promptly had a stroke, dying at age 51. Shortly afterwards, the state reinstituted some of the support payments (source item from Ben Bonnano).

*In the US, it is not only that people who are poor or have inadequate health insurance are less likely to have their ailments diagnosed early, but in addition, even when they have gained access

to the medical system, they will receive fewer services there, and get discharged earlier. For instance, this was found to be the case with sick newborns (Consumer Report, 3/92).

*A homeless man brought to an emergency room at Sunrise Hospital in Las Vegas was escorted out by security because he had no health insurance, and died on the lawn outside. Called to account, the chief nursing officer at Sunrise said, "we are all going to die" (Health Letter, 11/97).

*When people are hospitalized in the US, those who have no medical insurance have twice the risk of suffering injury due to substandard care than those who are insured, and this effect overrides factors such as race, income, or gender (IAETF Update, 2&3/93).

*When people hopelessly in pauperism are brought sick to a hospital in the US, they may receive a few days of care, and then the hospital may simply deposit them at the threshold of a shelter for the homeless, possibly still acutely ill, or at least helpless (NC Register, 20/12/90).

*One form of withdrawal of health care takes place when funding for the health care of certain devalued groups is made available, but under conditions that are so onerous to medical practitioners that they refuse to provide health services to people thusly covered. For instance, in some locales, families with mentally retarded members have had an increasingly harder time finding physicians who will accept them under Medicaid coverage.

*Edgerton, R. B., Gaston, M. A., Kelly, H., & Ward, T. W. (1994). Health care for aging people with mental retardation. Mental Retardation, 32(2), 146-150. The health status, health practices and health care of elderly retarded persons was found to be very much at risk. Retarded persons who lived with relatives or in community residences tended to receive adequate health care, but those who lived more independently had difficulty accessing such care.

*A spokesperson for the National Health Law Program in Los Angeles said in 1990 that "tens of thousands of people die every year in this country because they have no health care," and while "their death certificates may say things such as heart attack or kidney failure, they might just as well read 'uninsured'" (Modern Maturity, 10&11/1990, p. 32).

*One aspect of the despicable current policy of withdrawal of health care from the poor is not merely to "ration" health care, but to establish committees and hire "ethicists" to determine who will get what health services, and who will not (Time, 15/5/89). Not oriented to the higher order dynamics, many good people get roped into this kind of deathmaking participation, almost in the same role as the Jewish ghetto elders under the Nazis who would select the people to be shipped to the concentration camps.

*Even as the medical system creaks and groans, hospitals are collapsing from their own complexities, and poor people go without medical care, over 100,000 American women a year have been getting surgeries to enhance the (perceived) beauty of their breasts.

*We have warned that we are in the midst of a massive withdrawal of medical services from the poor, as part of a larger de facto genocidal policy. As of early 1989, the state of Oregon and the county of Alameda in California have become the first governmental units in the US to be designing an explicit rationing scheme of health care for the poor. Of course, the scene is interpreted as being rationally promotive of the largest good for the largest numbers, and as superior to the unexplicated random rationing schemes now operative. (NY Times, in Springfield Union News, 27/3/89; source item from Michael Kendrick.)

"Euthanasia" or Other Killings By Other Health Workers

*CBS TV's "60 Minutes" of 18/12/97 carried yet another reportage of a US Air Force medical technician who apparently injected patients secretly with dangerous drug doses so that they went into a critical stage--and then was always the first on the scene playing heroic rescuer, though some of his victims (most of them children) ended up impaired.

*In the intensive care unit of a county hospital in Terre Haute, Indiana, 150 patients died between 5/93 and 3/95. Many of the deaths were quite unexpected. A male practical nurse in the unit was suspended since his presence seemed to be the single most common factor in the deaths. Later developments suggested that he killed more than 100 patients by injection, but could be convicted for only 6. He was described as very caring, and sometimes kissed the patients before killing them (AP in SHJ, 12/97).

*A respiratory therapist admitted having suffocated or drugged to death 40-50 patients in a Calif. medical center. Colleagues have also been implicated (multiple 1998 sources).

*Sixteen percent of intensive care nurses in a survey said that they had hastened the deaths of supposedly dying people, usually by administering overdoses of narcotics or not administering prescribed treatments, 7% of these nurses having done so at least once or without the knowledge or consent of anyone else, including the patients; close to 1% said that they had done this in 20 or more cases (AP, in Syracuse Post-Standard, 22/5/96). Nurses' organizations were very unhappy with these findings, and even denounced them as invalid (SHJ, 25/5/96). The lead editorial in the Syracuse Herald-Journal of 25/5/96 said that the survey report of nurses killing their patients "shouldn't be seen as an indictment of nurses. Just the opposite. It underscores their humanity, the depth of their feelings for their patients...there are no villains."

*In Denmark, a nurse and a doctor secretly killed 22 nursing home residents with drugs. The nurse also stole money from the residents (AP, in SHJ, 21/10/97).

*In 1991, 4 nurses' aides were convicted in Vienna of murdering 40 hospital patients, but they may have killed well over 100 (various sources).

*Dr. Beine from Germany sent us an article which documented a number of serial killings by hospital personnel of their patients in Germany. In a number of cases, the wish to discredit or do injury to colleagues or superiors played at least some role in the motives of the killers. Frustration in one's life and work also seemed to play a role in some cases. One nurse's aide cited a new motive for her killing babies in her care, namely hatred of men, expressed by killing boy babies. One conclusion reached by the article is that personnel can easily get away with killings unless they kill too many people and thereby begin to draw attention. Secondly, the killers generally were competent and reliable workers and were not among the earliest suspects. Thirdly, the more people personnel killed, the more their inhibitions were lowered about killing yet more, and the more frequently they killed.

*There is something peculiar going on in that male nurses (and nurses' aides) seem to be proportionately much more involved in secret patient abuse, sexual exploitation, and patient killing, especially serial killing. We are not aware of anyone having made an analysis of what is going on.

Other Life-Endangerments in Human Service Contexts

*We have repeatedly reported that deathmaking can be very subtle and indirect, but render a person just as dead nonetheless. One of the big indirect contributors to deathmaking is formalistic, objectified, and even bureaucratic rules and regulations that hamper staff's judgment, and inhibit them from acting naturally and appropriately in a situation. One such strategy that has arisen in

group homes is the requirement that on-site staff contact a supervisor before acting in any emergency, e.g., when a resident appears to require hospitalization, when there is an altercation between residents or between residents and staff. In one group home recently, one of the residents began to vomit during the evening. On-site staff called the supervisor who said it didn't sound very bad, and gave instructions not to be further disturbed. The resident continued to vomit, eventually bringing up a brown-ish substance. Staff tried to contact the supervisor again that evening, but with no success. The next day, the resident was hospitalized and died shortly afterward. Whether the resident would have lived longer if immediate action had been taken may not be possible to determine, but one can certainly say that rules and regulations that require official permission before necessary action is taken will certainly not help to preserve the lives of vulnerable people. Further, if the inaction of the staff did contribute to the person's death, it most certainly will not be listed on the death certificate. This is an instance where staff on the scene should have followed their conscience and acted without regard to the supervisor's instruction (vignette submitted by Ed Cohle).

*In recent decades, research has made it ever clearer that both social isolation and social segregation are correlated with shorter life-spans, and we can safely assume that at least a proportion of this life abbreviation is due to all the things that go with social isolation and segregation. In other words, any systematic contribution by a human service to social isolation and segregation is a contribution to deathmaking.

*The reports by the various state protection and advocacy (P&A) agencies furnish a steady diet of horror stories. For instance, among other things, the P&A office of California (Winter 93-94) drew attention to so-called "transfer trauma" deaths, i.e., deaths resulting from clients being moved about from one setting to another.

*Senn, C. Y. (1988). Vulnerable: Sexual abuse and people with an intellectual handicap. Toronto: G. Allan Roeher Institute. Prepared under contract to the Family Violence Prevention Division, Health & Welfare Canada. In early 1988, the Canadian Association for Community Living, headquartered at the G. Allan Roeher Institute in Toronto, came out with a report on the sexual abuse of mentally retarded persons entitled Vulnerable. It noted that much of the research and literature in this area is filled with problems because of (a) difficulties of identifying abuse, (b) the fact that such persons often live in isolated and segregated settings, such as institutions, where the abuse may be undetected and unreported, and (c) certain characteristics of mentally impaired persons which may make them more vulnerable to abuse, less willing or able to report it, and less believable if they do report it. Nonetheless, even given all of these problems, the report estimates that at least 1/3 of mentally handicapped youths (at least in Canada) will be sexually abused in some way before they reach the age of 18. It further reports that in all existing studies, the abuser was known to the victim in 99% of the cases.

What studies there are on the sexual abuse of impaired persons show that it occurs in the community, and in family and particularly in foster settings, as much as it does in segregated institutional settings.

The report also notes that females are much more likely to be abused than males, but that once an incident of sexual abuse is reported, the reporting is apt to decrease the likelihood of its occurring again for males, while such reporting has little impact on the likelihood of the abuse recurring for females.

The report identifies a number of social and psychological/personality characteristics of mentally impaired persons which make them highly likely to be targets of abuse. These include the mentally handicapped person's (a) likely deprived emotional state, (b) likely social isolation, (c) likely powerlessness and sense of helplessness and lack of control, (d) likely ignorance of sexual matters, and (e) vulnerability to gestures of affection and fondness, and particularly to "treats" offered by loved adults. For instance, the "men's magazine" Hustler reportedly once tipped off its readers that mentally retarded girls were ideal targets for sexual abuse, because they would not be able to identify the abuser (Sank & LaFleche, 1981, cited in Senn, 1988). All the above

vulnerabilities certainly sound real, and would point to areas or strategies for programmatic address in the upbringing and socialization of such children.

Unfortunately, when it comes to making recommendations for what should be done, the report falls to the common, almost universal contemporary error of addressing the problem on a very low, technological level. For instance, one of the report's major recommendations to combat abuse is for sex education of impaired persons, particularly in childhood. It also recommends an orientation of parents and service workers to the issue, and careful screening of personnel for human service positions. While there is little doubt that certain kinds of sex education could indeed help children and handicapped persons to be able to accurately avoid or report sexual abuse, it hardly seems to be the answer, since the abuse is after all perpetrated by someone else, and the education does nothing to reduce the likelihood that abusers will try to abuse, and will often succeed. Also, the report says nothing about the contemporary social context of sensualistic hedonism, of throwing off of moral restraints, of the exaltation of sexually titillating media and entertainment, etc., that contribute mightily to an apparently ever growing pool of people who are inclined to commit sexual abuse against children and impaired persons, and who will do so.

We believe that the findings of this report are as relevant today as at the time of its printing. Furthermore, we believe that sexual abuse has many links to deathmaking.

The report also seems to have fallen for a peculiar irrationality. On the one hand, one of its major themes is the heightened vulnerability of mentally handicapped people, calling for all sorts of special measures. On the other hand, in cases where a mentally handicapped person (perhaps because of his/her own very vulnerability) commits a sex offense, the report says (p. 56) that more lenient treatment "is not called for." Perhaps this illogic reflects a hyper-normalization perversion, since it implies that mentally handicapped offenders would be treated as badly as offenders--at least those in jails and prisons--are generally treated. Instead, one might recall proposals put forth as long ago as in the late 1960s in connection with the formulation of a comprehensive continuum of residential services for mentally retarded persons, namely, a physically segregated residential "camp" for mentally impaired offenders, so that they would be physically separated from society whom they might endanger or who might be a danger to them, so that they would be removed from sources of temptation and opportunities for offense, but so that at the same time, they would not be subjected to the brutality and viciousness which is part and parcel of the prison system. This model was formulated as the "least worst" option so as not to either sacrifice the impaired person to the brutality of the prison system, or to justify the continued existence of large segregated mental retardation institutions even for this population. However, to our knowledge, the concept has never yet been implemented anywhere.

*McCartney, J. R. (1992). Abuse in public residential facilities for persons with mental retardation. Tuscaloosa, AL: Applied Research Bureau. (Final report of a research project funded by the Association for Retarded Citizens of the United States and supported by the Alabama Department of Mental Health and Mental Retardation). A relatively intensive survey of 23 US state institutions for retarded people found that those residents were the most likely to be abused who exhibited maladaptive behavior, and/or had previously already been abused.

*An investigation found that during 1989-1993, 340 children in the care of the mental health and mental retardation system of New York State died. Homicides, suicides and accidents accounted for at least 19% of these deaths. These data are based on children in merely two service systems in just one state (Quality of Care, 7&8/94).

*All sorts of dumping-related practices can be very deadly, even if indirectly so. Shortly after the TIPS editor came to Syracuse in 1973, he met a mildly retarded man who had spent years in institutions for the mentally retarded, and who had then been dumped. He quickly became a member of the street culture which seduced him into indiscriminate smoking and drinking. With a weak personality and poor self-control, he also began to eat indiscriminately, becoming obese. Being commonly homeless or living in shelters, in combination with all the above, soon made him a walking medical wreck. For instance, the drinking, smoking and obesity soon began to destroy

his cardiac system. When he had acute health problems, he would go to a public hospital for treatment, and of course they commonly prescribed drugs, an increasing number of which he had to take on a chronic basis. Thus, when he was released from the hospital he might be on 7, 8 or 9 different drugs, each to be taken at different times at different dosages. With his limited mentality, and in his often intoxicated and disoriented condition, he was really not able to keep up with this drug regimen and might take or skip drugs at random. By sheer coincidence, the TIPS editor happened to be on the spot at one occasion when he collapsed on the street, and the ambulance had to be called to take him to the hospital. He was carrying a large plastic bag with 11 of his drug containers on him, and there were so many of them that the ambulance drivers shook their heads in bewilderment. Even though his medical condition got worse and worse, nothing could keep him from his destructive lifestyle of "independence" and "self-advocacy." In early 1990, several of his systems gave up at once, and he died after several weeks on extensive life supports in the hospital, only age 44--in other words, about 30 years short of a normal life expectancy--but already looking like 60. Thus, the TIPS editor had seen him go from a young adult into old age in little more than 16 years, and one can say emphatically that he had eaten, drunk, and drugged himself to death.

The case is a dramatic example of indirect deathmaking where somebody's life is dramatically abbreviated via a sustained process of marginalization and disguised and indirect forms of deathmaking, but nobody seems to be at fault. It is because such deathmaking is so well concealed that very few people commented on it when he died. In his life-long deviancy career, he must have been listed hundreds of times as a successful closeout in all sorts of human service statistics--a point which we make endlessly at our workshops.

Many mildly retarded people can make it through life, though many also do come to grief at various times when there is a crisis. However, mentally handicapped people who have grown up in institutions and then been dumped often cannot manage their lives in a competent fashion. In this age of irrational individualism and self-centeredness, there pervades a massive ideological conviction that such people should simply be given their independence come what may--in other words, to "die with their rights on." We do not share this decommunitizing modernistic ideology since we do not believe that all humans are islands unto themselves, and that no one has obligations to anyone else. What this man needed was life-long supervision, and perhaps a partial form of guardianship, though we are under no illusions that in the current societal and human service climate, he could have gotten this, or would have done better had he gotten it.

*We met a man who was released from a psychiatric institution into "independence"--in effect, the streets. He told us that he had been arrested for assaulting a police officer, and was offered a choice of spending 2½ months in the forensic unit of a psychiatric institution (these are the units for people judged not guilty by reason of insanity, and/or for people accused of both having committed a crime and being insane), or of going to trial and likely receiving 3-6 years in state prison. He chose the psychiatric institution--perhaps not a wise choice, all things considered, especially since the charges were eventually dropped, so he would not have had to spend <u>any</u> time in prison. While he was incarcerated in the institution, he was given an injection of the powerful drug Thorazine. He had a bad reaction to it, and had to be rushed to a "real hospital" for emergency treatment, without which he would have died.

*We have mentioned before that one form of deathmaking is placing handicapped people into community settings that are fire hazards. We continue to receive all sorts of clippings of fires in which handicapped or elderly--and usually several--persons have died.

*During 1990-91, there was a great deal of publicity in the Australian media about the atrocious conditions at a mental retardation institution in the Australian state of Victoria that was commonly referred to by its location as the "Stawell Centre," which is rather ironic in that it would be pronounced like "stay well." This included 51 charges of sexual assault, and up to 12 suspicious deaths, all this in a relatively small institution for 100 retarded people.

*Don't put Old Bones in charge of an institution. On 28/3/93, a newspaper in Sydney, Australia (The Sun Herald) carried the headline "Hostel of Horror: Residents Suffer Amid Killings, Sex Assault." "More than 150 'mentally retarded' men and women are living in shocking conditions in an isolated...bush hostel owned by a former psychiatric hospital nurse. They are stripped of their invalid pensions and a few are paid a pittance. They roam about unsupervised...many copulate openly. Some have died...A female inmate was strangled recently while taking a bath. Another was hit by a car while playing 'chicken' on a six lane expressway. Others--often befuddled by drugs--have wandered off over the years and drowned." Eventually, we are told why all this has been happening for almost 20 years: "...Confidential government reports...blame negligence by the skeleton staff for their deaths." (From an article by Michael Steer in the Australian Disability Review, No. 1, 1994.) We could have told them this; skeletons should never be hired in human services, regardless of what the law, the ADA, funders or the government say.

*Quality of Care (11/95) has documented a new version of agency deathmaking. A resident develops symptoms of a somewhat ambiguous nature which residential staff report by phone to a nurse or physician who is stationed somewhere else. The latter instruct the staff to "watch the resident closely"--which they in fact do as the resident fades away and dies, sometimes in a matter of hours and sometimes over days. Perhaps residential staff on the spot are not intelligent enough to understand what the medical higher-ups mean by "watch," and thinking very concretely, they assume that it means no more than keeping a person within eyesight. Alternatively, not having been told more specifically what to do, such as measuring specific vital signs, residential staff may be too intimidated to bother a higher-up person once again.

*Amazingly, 84 residents of psychiatric facilities in New York State hung themselves in a 5-year period. Of these, 34% were supposed to be under special suicide observation. In nearly 50% of cases, the people hung themselves within 15 minutes of being observed by staff. Prescribed suicide observation was only being carried out in half of the cases (NYS Comm. on Qual. of Care, 5/1989). We do not recall this being reported in the generic news.

*The skeleton in the closet; or when you are not there, you are not missed. In New York State, an institution with 360 beds could actually be certified as an "adult home." One such home is called the Leben Home for Adults, Leben being the German word for either "life" or "to live." The trouble is that in this home, residents were getting killed. In one such incident in 1990, the decomposed body of one resident was found in her bedroom closet, which had been locked from the outside. Apparently, no one had missed her (QOC, 1&2/91).

*The New Queen Esther Home for Adults in New York City was declared by New York State's Protection and Advocacy Office as being literally "out of control" in view of dirty and unsafe living conditions there, and the rampant violence of its residents, often resulting in staff calling in the police. Also, there has been a series of deaths by violence. These conditions were created by the home accepting extremely disturbed people from the state's mental institutions, with these mental institutions gladly dumping these people in facilities such as this one (NY Quality of Care, 6&7/93).

*In 1994, the NY State Office of Mental Health proposed ending the use of straitjackets in its mental institutions, in part because of the large number of inmates who died while under restraint (Syracuse Herald-Journal, 27/7/94, p. B9).

*In the statements of client rights of all sorts of service providers, one may find that several rights may have to do with the "right" to be made dead, to refuse resuscitation or medical care, or to have one's organs taken. It is ironic that cost-cutting deathmaking measures may be phrased as rightful entitlements of the victim, which once again goes to show how slippery or tricky rights can be.

*One of the participants of one of our workshops has referred to what happens to so many human service clients these days as "being serviced to death."

*In the Syracuse area, a home for 8 debilitated women in their 80s and 90s cut out all staff presence between 7 p.m. and 7 a.m. in order to save money. This despite the fact that not long before, a 94-year-old woman in the home had broken her hip during the night (SHJ, 10 March 94).

*Prescription mind-drugging is very unhealthy, and often deadly. Here is an extraordinary exemplification of this, as well as of the bankruptcy of our human services. At the Central State Hospital in Indianapolis, Ind., a woman diagnosed to be both mentally retarded and schizophrenic had been put on 3 psychoactive drugs and 2 anti-convulsants. Her room window had been stuck open for a long time, similar to many windows in a number of other rooms in the building that were broken or unworkable for up to a year! One day when it was 18 degrees outside, she went into her room to take a nap, and four hours later she was found frozen to death, at least in part because the drugs had depressed her central nervous system which regulates body temperature, and probably also had depressed her self-preservation capacities. An investigation into the death found that it only took five minutes of effort by a workman to close the broken window so as to keep the cold air outside, but that the nurse on duty at the time of the death had worn two sweaters to keep herself warm. The response of the state Mental Health Department was very typical: it instituted a daily blanket count to make sure that there were always enough of them, installed thermometers in each ward, and established a new set of rules on how to handle maintenance requests. Tragically, a 40-year-old woman with the same diagnosis and on the same kind of drugs had died of heart failure in the same facility as a result of the drugs only a month earlier (several Indianapolis Star news items between 12/91 and 3/92; source items from Joe Osburn).

*One problem with physical altercations between a client and staff members is that so often after staff members have "won" the physical contest (as they almost inevitably do), the client is put into some kind of restraint. In turn, physical restraint has been shown to be attended with all sorts of other problems, such as unnecessary or excessive force, psychological, physical or sexual abuse, outright injury, being restrained for long periods and without an opportunity for exercise, temporary food deprivation, and being prevented from relieving oneself (e.g., Quality of Care, 1994).

*In Buffalo, NY, a young male home health care aide stabbed a 70-year-old invalid to death in an apartment where the aide had been working, and then calmly absconded with the man's TV set (AP, in SHA, 1 Nov. 92). In the very same newspaper issue, there also was an article about a home care worker in the Syracuse area stealing $100 from the elderly couple for whom the aide was working, and whom they entrusted with cashing their checks. The agency that employed the aide did not have to make any restitution. Hilariously, the article reassured readers that "the majority" of home care aides are trustworthy and caring. We worry about the very competency-reduced people in the care of the other 49%.

"Euthanasia," Murder, or Abuse by Private Citizens

*A study showed that elders abused or even only neglected (outside of service contexts) were 3 times more likely to die during a 13-year follow-up period than their peers (Time, 17/8/98).

*A former president of the Colorado Foster Parent Association shot to death his 23-year old adopted son who had cancer (IAETF Update, 11&12/92).

*The press, that is forever on the side of deathmaking of the afflicted and handicapped, described the handicapped child gassed to death by her father in Saskatchewan, Canada, as "suffering the fearsome pain of advanced cerebral palsy...that kept her in agony," and later added "...constant agony" (NY Times New Service, in SHJ, 1&2 Dec. 97). We were not aware previously that there were such things as incipient, advanced, and in-between stages of CP. Almost everybody wanted

the father to be exonerated, and his first conviction was set aside. In a second trial, he was sentenced to a mere year in prison and a year of confinement to his farm.

*There are circles in Canada that started to demand in 1997 that judges be allowed to pass sentences of "compassionate homicide," which is intended to let off the hook people who have committed "euthanasia," such as parents who kill their impaired children.

*The Hemlock Society also came out in 1997 with a demand that people who kill any ill or handicapped persons be given leniency because these should be treated as "special crimes of compassion" (Mouth, 3/98).

*In Britain, a woman killed her elderly mother who had a neurological disease, and in gratitude, the court sentenced her to only two years' probation (in 1989), and the popular media have been lionizing her ceaselessly. Among other things, the BBC made a special drama about the case, entitled "In My Defence: I Will Show You Mercy."

*Who said you can't take 'em with you? A new twist on the old practice of elderly parents killing a dependent handicapped son or daughter and then themselves occurred in Philadelphia in 1990 when a 49-year old cancer specialist killed his arthritic wife, their 17-year old severely retarded daughter, and for good measure, and apparently out of intended kindness, their 12-year old unimpaired son lest he become a ward of the state (SHJ, 18/7/90).

*A man in California who was a fanatic devotee of cryonics removed his 83-year old mother from a nursing home, gave her a lethal dose of barbiturates, had her head cut off while she was still alive, and had it put in liquid nitrogen in hopes that science would one day be able to resurrect her. However, because of court interference, prosecutors had to end their investigation of this homicide (NC Register, 1/6/91).

*The editor of the journal of an association of parents of retarded people in Britain commented very sympathetically about a mother who removed her impaired 14-month-old child's breathing tube in a hospital so that it died (Speak Out, 11/97).

*A Massachusetts couple decided to take in the husband's dying mother. To their amazement when the mother was discharged to them by the hospital, they were given a large stock of morphine and a signed undated death certificate. Criminologists and mystery writers talk about suspects in a killing having had the means, the opportunity and the motive. Here, people were given the means and the opportunity to kill, and a very strong suggestion that they do it.

*The PC crowd, the self-advocacy proponents, and the legal rights and self-determination advocates have all been thrown into a schizophrenic tizzy by the infamous Glen Ridge case in New Jersey. In 1989, 13 high school athletes sweet-talked with promises of a date a mentally retarded female age peer (age 19, reported mental age of 8) into the basement of one of their homes, and with her free consent--i.e., without force, threats and without any promises of rewards--got her to engage voluntarily in a variety of sex acts in the presence of the hooting boys. Also, once they were in the basement, there was no further trickery. Among other things, the young woman actually asked to be penetrated with a stick, broom handle and baseball bat. To their credit, five of the 13 left when they saw which way things were going. The media and courts have interpreted this event as an "assault," and eventually four of the youths were convicted (some sentenced to up to 15 years in detention). But after the event, and throughout the 1993 trial, the retarded woman expressed continued strong likings toward the boys, said that they were nice, and she would like to be friends with them--and above all, she did not like being referred to as "mentally retarded."

The reason for the above-mentioned tizzy is because according to the religion and propaganda of these parties, this would be a case of self-determination and "freedom of choice," and the young men should never have been indicted. After all, the victim had been in the community for many

years and possessed good verbal skills, and had only recently been placed in special education. On the other hand, these self-same parties were outraged (as usual) and screaming for vengeance, and called the sexual activities a "hate crime."

The jury itself was easily convinced of the retarded woman's mental competence, but then, they are ordinary people rather than PC intellectuals or stooges.

Apparently, one of the ways the above parties are trying to weasel out of their ambiguous and self-contradictory position, wanting it both ways, is by calling for more sex education, or what they have begun to call "social-sensuality training," believe it or not (from miscellaneous clippings).

Interestingly, AAMR News & Notes (7&8/93) referred to the event as a "hate crime," when in all likelihood, it was really a crime of sexual opportunity.

*In programs that teach handicapped people what to do when they are victimized, they are told to scream "fire" rather than something such as "rape" or "help" because people are more likely to become involved in response to a fire call than a crime call (SHJ, 23/7/92).

*One amazing thing is how an evil invention these days gets so rapidly copied all over the world. For instance, no sooner had juveniles in the US discovered the joy of setting sleeping street people aflame than similar people--almost invariably juveniles or young adults--began to do the same thing in other developed countries around the world. Since the perpetrators are usually not the kind of people who do a lot of reading, one has to assume that they watched TV news of such events, and that this made such a big impression upon that they tried to imitate the deed. This also underlines the power of modeling--even if negative--to elicit imitation, even when the model is a mere verbal or pictorial facsimile.

Deathmaking by Multiple or Indeterminate Parties

*We now have accumulated enough evidence to be able to say that with extremely few exceptions, everybody who promotes abortion, infanticide, suicide or "euthanasia" rejects the reality of a deathmaking slippery slope--and perhaps any slippery slope. However, and amazingly, some of these people occasionally warn of slippery slopes in the opposition to deathmaking, i.e., that one kind of effort to block deathmaking might lead to successful other such efforts.

*The Department of Developmental Services of California's Office of Human Rights has estimated that 50-90% of persons with developmental impairments will be sexually abused during their lives (The Arc, Winter 1985). The incidence is bound to be high, but no one really knows how high.

*Halpern, A. S., Close, D. W., & Nelson, D. J. (1986). On my own: The impact of semi-independent living programs for adults with mental retardation. Baltimore, MD: Brookes Publishing. According to the 1985 book On My Own, 21% of retarded persons moving to their own apartments experienced some kind of sexual abuse within the first few months.

*A British study has underlined what we have taught about the risks to retarded people in today's society. In a large number of adults who reported having been sexually abused, it was found that the abusers were usually close-up people rather than strangers, including family members and service staff, and that it occurred most often in the home of the victim or of the perpetrator, or in a day service. While almost all perpetrators were male, about half the victims were also males (Speak Out, 3/97).

*A disfunctional mother in New York put her 8-year-old cerebrally palsied boy on a school bus to his special education class. When the bus arrived, the boy was dead. On the one hand, it appeared that he had been dead when the mother put him on the bus, but on the other hand, the bus escort said they were trained not to interact with or touch the children, and that it was not their job to take care of them (e.g., SHJ, 20/9/95).

*A German physician by the name of K.-H. Beine has written a 600-page dissertation on secret and illegal killing of patients by health care personnel in health care settings, with major focus on such events in German-speaking and English-speaking countries. However, some cases in other countries were also examined. The documentation for many of his cases he received from the Training Institute with which he had been in communication for several years. (Interestingly, the author could not find one single documentation of such a killing in a so-called underdeveloped or developing country, though, of course, this is not to say that they do not occur there, though the motives may be different.) Many cases were systematically documented, particularly where it came to a trial, in which case the details of the case were usually revealed more fully. Some malefactors, once they started killing, killed a number of people in very quick succession. Some malefactors managed to kill several victims in a day and still were not caught until months later. In some such cases, as many as 50 people were killed by a single malefactor. Some managed to kill over many years before they got caught. A number of the killers even brazenly predicted the times of death of their victims and then made sure that the prediction came true. The vast preponderance of victims were elderly. Surprisingly, relatively few of the victims were isolated people without family support. In many cases, the victims knew that killing was going on, and that they were almost certain targets thereof, told their relatives and friends before it happened, but nobody believed it.

One finding was that women were more likely to kill men, and men were more likely to kill women. Only one of the many malefactors had previously been under mental treatment, much like the Nazi killers seemed to be such ordinary people. Some victims were killed through methods that took minutes to hours, and were extremely painful or stressful, rather than being instantaneous or painless. Thus, one can hardly call these "mercy killings." Interestingly, in some cases the killing was done with an injection of Rohypnol, which is the so-called date-rape drug. How strange that so often there are links between death and perverse or immoral sex!

The tome also included a review of 17 published surveys of opinions of health care personnel about "euthanasia." A copy of the dissertation can be inspected in the TI office.

*A survey of physicians and nurses in South Australia, published in 1994, found that in half of the cases where physicians admitted that they had carried out "euthanasia," there had been no patient request or consent (Weekend Australian, 3 June 95; source item from Peter Millier).

*An Australian law professor wrote the newspapers that giving lethal injections was illegal but administering lethal doses of morphine "against pain" was not, and that people "caring personally and professionally" for impaired infants should take note. In other words, he was advising people how to kill legally. (Mail on Sunday, 23/7/95, source item from Speak Out.)

*At the 1996 US Conference on Voluntary Euthanasia, the main theme was "death is not the enemy, suffering is." The luncheon talk was "maximizing options for a good death," which is a rather grotesque topic for a mid-day lunch. Another major presentation was "avoiding failed attempts at self-deliverance" (source material from Marcia Tewell).

*The quality-of-life culture has now given rise to talk about the "quality of dying," and a major Canadian "euthanasia" organization has named itself "Dying with Dignity: A Canadian Society Concerned With the Quality of Dying."

*A survey revealed that people with terminal diseases who were in favor of "euthanasia" were motivated not so much by pain as by depression, even though the traditional argument had always been pain-based. For liberals and modernists, this raises the "ethical dilemma" as to why they, who are always so quick to recommend that people go to shrinks, should favor "euthanasia" rather than shrinkery for people who say they want to die.

*For the sake of new readers, and of old readers who may have forgotten, we reiterate that pro-"euthanasia" story lines are now an extremely common theme on TV, both in the fiction, documentary and news categories. Such story lines have appeared on ER, Chicago Hope, Sisters,

and Law & Order among others. Simplistic stereotypes abound: opposition to "euthanasia" is usually interpreted as coming from religious fanaticism; one would never learn that advocacy groups for or on behalf of handicapped people are mostly vehemently against "euthanasia" and assisted suicide; and the deathmakers are almost invariably portrayed very positively, be they human service workers or relatives. Realities such as the ambivalence of people contemplating suicide, and alternatives such as hospices are rarely covered.

*Propaganda for killing the afflicted can be sneaked in most subtle ways into all sorts of entertainment, in ways which the vast majority of the citizenry would not recognize. For instance, in a 1995 episode of the TV series "Hawkeye" (about Leatherstocking), an insane person was interpreted as killable because the person was described as "not a human being."

*China will soon have 130 million people over 60--and few young people because of its one-child policy. One adult may soon have to take care of 2 parents and 4 grandparents (Ind. Star, 14/7/96; source item from Joe Osburn). This is a scenario for state-promoted large-scale "euthanasia."

Privatization of Deathmaking

As we keep pointing out, there has been a trend toward "privatization" of all sorts of killings, starting with abortion, moving to the deathmaking of impaired newborns, then to the killing of a violent spouse, etc.

*A woman in New York State killed her two young sons because she feared that the children would be taken away from her because of the family's poverty. The husband said that she did this because she loved them, and invoked increasingly common privatization arguments that "it was their mother's place, she gave them life and she took it back" (AP in SHJ, 18/10/94).

*At one time, parricide was considered to be the worst crime there was. Now, there is one lawyer who does nothing but defend children who killed parents, who by late 1992 had defended 100 such children (CBS TV "60 Minutes," 29/11/92). One teenage girl systematically shot her father 6 times, and because he allegedly had beaten her, "60 Minutes" approved (29/11/92).

*A Calif. mother shot the man being tried for molesting her son. She was herself freed by a jury (Time, 23/8/93) to much public acclaim.

*Apparently, the doctrine that women should be legally free to kill men who beat them was formulated by lawyer Cynthia Gillepsie in her 1989 book, Justifiable Homicide. She died at 51 in 2/93. At any rate, across the US, there is a steady trickle of pardons being handed out to women who killed their husbands or lovers who allegedly were abusive and apparently "deserved" killing (Time, 23/12/96). For instance, in summer 1995, Governor Jones of Kentucky saw a quilt displayed at the state fair in Louisville that had been made by Kentucky women who were serving prison terms for killing, or trying to kill, their husbands or lovers. The governor was moved to tears, and on his last day in office, he pardoned nine of them (Time, 25/12/95). In Florida, men-killing women have been freed under a so-called "battered women's syndrome process" (SHJ, 10 March 93; 15/7/93). This "syndrome" has also been invoked in the release of men-killing women in Missouri. Some women have caught on: one shot her husband in his sleep in NY, claiming he abused her, but even her own children said that she had been the abuser (SHA, 17/11/96). Some women are only getting token sentences (e.g., 3 months) for killing their men (Free Press, 24/7/95).

*More coincidences. One of the leading promoters for privatization of husband- or lover-killing has been an artist by the name of Candice Slaughter (Time, 22/3/93).

Sympathy for the Deathmakers

Whenever someone kills an afflicted person or a baby, there is a vast outpouring of sympathy for the killer. This reflects 3 dynamics. (a) People harbor all sorts of killing thoughts, and feel identified thereby with the killer. (b) People may harbor specific resentments toward the kind of person who was killed, and feel that the killing was appropriate. (c) The killers are a concrete living reality, while the dead-and-gone victims are an intangible idea. One never meets them, gets to know them, hears them speak, etc., and therefore also does not mourn for them.

Obviously, the items below are closely related to the privatization of deathmakings covered earlier.

*Just about everybody has heard of the trial of Claus von Bulow who was convicted of at least twice trying to kill his wife by means of insulin injections. According to the newspapers, von Bulow had not visited his comatose wife for almost four months; nevertheless, when von Bulow left the courthouse on bail pending an appeal, a crowd of about 200 people broke into cheers and applause (Virginian Post, 8 May 82). In the TIPS editor's opinion, this reflects the currently normative lack of sympathy of the public with victims, and particularly with people it sees as "better off dead."

*Another striking example is the 1991 Delbert Ward case in northern NY. Delbert was charged with smothering his brother in his bed, to which he confessed. Both were mentally retarded. We suspect that kinky sex was involved. The people in the community rallied around Delbert. The liberal press did too. Five music groups performed benefits on his behalf, and a prize-winning movie ("Brother's Keeper") was made on the case. Delbert was acquitted and became an international cult hero, the prosecutor had to leave town, and the police officer who had arrested him sold his house and moved away.

*About 2% of all US homicides involve children killing their parents. Increasingly, it is teenagers who are killing their parents, and claim that they had been abused. Also increasingly, the public sympathizes and approves, as it does of the killing of men by their women, all of this being in the category that we term "privatization" of deathmaking, which largely removes such killings from the domain of police matters, illegality, prosecution, etc. Such youngsters are often acquitted or not prosecuted even when they have systematically planned the killing, rather than having acted in immediate self-defense.

*By 1992, there were 650 women in California prisons alone for killing their husbands or lovers, supposedly after having been abused by them. A lot of people (generally, the PC crowd) would like to spring all such women via gubernatorial clemency (SHJ, 20/7/92).

*A Fla. woman convicted of shooting her drunken lover was sentenced to 8 years, but was freed pending her appeal--and her appeal was simply not acted upon for 16 years (AP in SHJ, 17/9/98).

*After a physician in England killed a 70-year old woman with an injection, a jury convicted him of "attempted murder"--but it was a jury weeping in sympathy with him (Mail, 20/9/92).

*Many killers of ailing spouses either get off scot-free, or get token sentences. A Stanford professor who strangled his ailing wife "because he loved her" got off with probation and community service.

*A man and wife in Nova Scotia smothered the wife's elderly father, and an elderly wife in Ontario stabbed her aged husband seven times until he died. All three perpetrators received suspended sentences because everybody felt sorry for them (CHN, No. 9, 1995).

*In Utah, a judge said he did not know what to do with a 22-year old woman who had let her newborn baby die, and opined that there ought to be a balance between "punishment and the therapy you so obviously need" (AP in SHJ, 15/9/98).

*The same dynamic that is at work in people's inclination to let mercy killers off the hook can also be encountered in people's reaction toward murderers who went undetected--or at least unconvicted--for a long period of time, and finally got found out. Even when the evidence is quite adequate, it is difficult to get convictions; and if convictions are gotten, sentences are often light. People's sympathy is with the live person before them, whereas the murder victim is an unknown shadowy abstraction 10 or more years in the past (Newsweek, 12 Jan. 98).

*We remind readers of the vast sympathy for O.J. Simpson, and for the English nanny who shook a baby to death recently.

*Whenever a child dies because its parents do not take recourse to modern medicine for religious reasons, the same kinds of people who ordinarily sympathize with the deathmakers call for the scalps of such parents.

More on Advocacy For or Against Deathmaking

*The Right to Death was the title of a book published in German in 1895 by the German jurist Adolf Jost. This book was an early advocacy of the killing of the afflicted, and fueled the ideology and practices later adopted by the Nazis. The phrase "right to death" was more recently adopted by the deathmaking lobby in the form of "the right to die."

*While the deathmakers adamantly deny that one kind of deathmaking leads to another in a slippery-slope phenomenon, one thing that is certainly not deniable because it can be empirically proven is that the arguments on behalf of one kind of deathmaking will eventually and inevitably be found to be invoked on behalf of one or more others.

*The old-fashioned phrase, "standard of living," seems to have been largely replaced by the new craze phrase "quality of life." This is yet another example of a phrase being systematically propagated because among its many connotations or applications is a deathmaking one (the same as with the word "choice"), which of course would not be the case with a phrase such as "standard of living."

*An 8-part series of articles appeared in the Toronto Star, 15-22 October 1994, on "euthanasia" and the "right to die" (source items from Beth French). It focused on some famous Canadian cases (such as that of Sue Rodriguez), the situation in the Netherlands, and the provision of palliative care and home/hospice care to "dying" people. It spelled out fairly clearly most of the motives behind these movements, such as the demand to be in control, and the decline of religious faith and its influence over people's behavior and public policy; identified some of the dangers, such as the extension of voluntary to involuntary dying, problems with the vagueness of living wills, etc. But in the end, it concluded that some sort of aid-in-dying is desirable and should be made legal, and that it will be possible to do so with sufficient safeguards that will prevent the slippery slope from resulting in the deaths of the weak against their will. So at bottom, the issue was interpreted as one of individual autonomy and will. Also, the writers seemed to think that it is impossible to talk about death and dying, and the alleviation of suffering, without at the same time talking about the possibility of "euthanasia" or assisted suicide as an option.

*Journalist Suzanne Rini has characterized bioethics as "the new pagan priesthood that supplies the value system for the new eugenics" by "transvaluing all that is evil into new 'goods'" (Communiqué, 10 March 95).

*People who somehow have achieved publicity or prominence helping other people kill themselves, or actually killing them, can very quickly become popular on the speaking circuit. An example is George Delury, who spoon-fed a lethal dose of anti-depressants to his invalid wife, and got away with a 4-6 month prison term. Among others, the American Psychiatric Association invited him promptly to lead a symposium on "assisted suicide" (NRLN, 20/5/96). He had presented himself to the court and the media as a loving husband who had reluctantly acceded to his wife's wishes. Only later was his computer diary discovered in which he described his wife as "sucking my life out of me like a vampire," and a "burden" (NRLN, 12 April 96). It also turned out that before he killed his wife, he had plundered her pension fund. Once again, the selfish motives in so much deathmaking stand revealed, and being a very close family member simply cannot be assumed to mean that one is acting in the victim's best interest.

Sometimes, it takes little more than an advocacy of deathmaking for one to achieve the status of "bioethicist."

*The four largest bioethics societies in the US held a joint 3-day conference in 10/94 which somebody called the "Woodstock of bioethics," with 900 bioethicists from 11 countries and 47 states attending. It was announced that the conference had addressed "controversial ethics issues" that "touch every person's life." Noting that this meant talking about cutting people off from life supports, helping people kill themselves, rationing health care and generating life artificially, we are inclined to believe it (source item from Joe Osburn). We suspect that the demons were flying in greatest excitement and in vast numbers in, over and through the conference.

*There are "bioethics" workshops that very systematically teach people in all sorts of medical fields to accept abortion, infanticide, suicide, and "euthanasia," according to a 1993 book by R. Bell entitled Prescription Death: Compassionate Killers in the Medical Profession.

*An "ethics" teaching videotape is entitled "A Fate Worse Than Death." It looks at the "complex moral and legal dilemmas" posed by "such tragedies" as "a loved one in a coma or vegetative state" (Fanlight Productions). Another video in the same series is entitled, "Help Me Die," and got an award from the Retirement Research Foundation. Maybe "retirement" will soon be the new code word for death.

*We were taken aback to learn that the major article on ethics in the most recent Encyclopedia Britannica was written by one of the world leaders in deathmaking, Peter Singer, who is also one of the leading promoters of animal rights and author of the book Animal Liberation. Singer has advocated the deathmaking of impaired people and unwanted babies. Unfortunately, he is moving from Australia to Princeton University's Center for Human Values(!) as--wouldn't we know it--professor of bioethics. (Source information from Barbara Fisher.)

*Two 1994 television programs, both about hospitals, "Chicago Hope" and "ER," promptly began to endorse deathmaking. For instance, in one episode of "Chicago Hope," a girl with anencephaly was born at the same time as another little boy was "in need" of healthy organs. Of course, the little boy was pictured as darling, and the anencephalic newborn as barely human, and referred to as "the organ donor" by the doctor. Further, the anencephalic girl's mother was portrayed as a Catholic who prayed her rosary beads--a most old-fashioned Catholic!--and who named her baby "Mary Margaret," a stereotypically Irish-Catholic name, thus interpreting those opposed to deathmaking as hopelessly "quaint."

But in a major story on the program "ER," Newsweek magazine reminds us that television is not real life: the TV show depicts people wandering in from the street without being checked by police, whereas in a Chicago hospital, there are several layers of security in order to, among other things, prevent gang members from stealing the bodies of their victims so that they can dismember them (Newsweek, 31 October 1994, p. 49).

Then again in an "ER" episode broadcast 1 Dec. 94, the physicians tried to talk an older man into taking his ill wife off a respirator because she said she doesn't want to suffer. He finally agreed to do so, and she did die. The deathmaking propaganda of these series has continued since then.

*There is an organization called Priests for Life. We wonder if there is also an organization called Priests for Death, or one in which priests who were not for life would operate without acknowledging that they are in favor of death.

*We were somewhat amazed to note in 1995 that a Catholic book publisher, Sheed and Ward, carried a large number of deathmaking videotapes, many of them featuring people well known to be leading deathmakers (source item from Jan Doody).

*To our surprise, we discovered that an entity that calls itself an "Advocacy Center for the Handicapped" held what amounted to a pro-deathmaking workshop under the slogan of "choice"--in a "fully accessible" hotel in Ottawa, the capital of Canada, in 1994.

*There is an organization called Pro-Life Alliance of Gays and Lesbians, which unfortunately yields the acronym PLAGAL, which sounds like "plague all."

*Some handicapped people opposed to the movement to make handicapped people dead have founded an organization called--for better or worse--Not Dead Yet (source item from Paul Tabor).

*The rock groups Marilyn Manson and Nine Inch Nails led 15,000 teenagers at a rock concert in Philadelphia in the chant of "kill your moms and dads" (CRTIR, Spring 95). Shortly thereafter, three teenage boys killed their parents, two of them in Pennsylvania. Statistically, it is extremely rare for a child to kill both parents at the same time.

*Some people are opposed to laws and regulations supporting safety of products, in the workplace and in other settings, because "danger is nature's way of eliminating stupid people... We need accidents... Future generations will thank you" (Harper's, 11/94).

*A bill was introduced into the California legislature that would exempt persons who are mentally retarded from the death penalty. The board of directors of the state's protection and advocacy office decided to oppose this bill--because it would exact too great a cost "to recent gains made in breaking down negative stereotypes." One argument was that such a bill would "pave the way to exempt them from other rights and responsibilities" (Calif. P&A Newsletter, summer 1993). In other words, advocates for mentally retarded people want them to have the right to be executed. Yet Robert Perske pointed out (The Arc, 7&8/93) that it is not uncommon for mentally retarded people to be falsely convicted, condemned to death, and executed, among other reasons being that either they are coerced into confessions, or convicted via plea-bargaining ploys by non-retarded accomplices.

This is yet another example of the minds of alleged advocates of retarded people having gone haywire, in part having been scrambled by the insanity of the recent PC rights, empowerment, and self-advocacy crazes. We should also note that in order to take this position, one would have to be in support of the death penalty in principle to begin with.

*Stung by the vast sympathy in Canada for the killing of a handicapped teenager in Saskatchewan by her father on ostensibly compassionate grounds, the organization founded by parents of retarded people in the Canadian province of Manitoba passed a resolution in 10/97 that "all human life is inherently worth living," and that "killing people who live with a disability...can never be justified" (source item from Zana Lutfiyya). The TIPS editor had warned the parent associations decades earlier of the deathmaking threat. Also, the association (on the national level) had pondered for 2 years publishing the TIPS editor's monograph on The New Genocide--and then turned it down. The vultures have come home to roost.

*In early 1994, Supreme Court Justice Harry Blackmun, one of the foremost and long-term proponents of abortion on demand on the court, declared himself opposed to all death penalty laws and said that he would "no longer tinker with the machinery of death" (AP in SHJ, 23/2/94).

*A cartoon poked fun at the incoherency of most people's position on life and death issues (and deathmaking) by depicting a criminal condemned to death who contracted a life-threatening disease. In order to avoid both capital punishment and the painful death predicted for the disease, he wanted to commit suicide. The politicians wanted to make sure he did not succeed on the grounds that prisoners should not have rights to "assisted suicide" that are not even permitted to law-abiding citizens (source item from Judith Sandys).

*One can now get all sorts of anti-deathmaking information from various electronic bulletin boards. Apparently, information about access to all of them is available from 301/251-9206.

Deaths of Vulnerable People from Salmonella & Other Bacteria

*For years, we have reported on, and warned of, salmonella poisoning, particularly in human services such as nursing homes, hospitals and other institutions. The increasing virulence of this organism has contributed to the deaths of many people, particularly vulnerable ones. The first time we gave our sanctity of life workshop in England in the summer of 1988, among other things we warned the audience to be on the alert for salmonella outbreaks, especially in vulnerable populations. Apparently, nobody in the audience had ever heard of this being a danger. Only months afterwards, a national scandal broke out when it was announced that salmonella poisoning was, in fact, epidemic in the UK, and outbreaks within a variety of human service settings were admitted to have already occurred, and to have killed people. There were 46 outbreaks in October 1988 alone affecting at least 1,000 people who had eaten eggs. The government did a typical empire thing. The health secretary said that "healthy individuals need not be too worried" and should keep eating eggs. No mention was made as to what might happen to vulnerable groups. Egg producers were furious that the issue had even been raised, being more concerned with the large egg products market than with people dying from salmonella (AP in SHJ, 6 Dec. 88).

*Now, we are beginning to see reports that another bacterial strain may assume a similar--and possibly even more dangerous--role, namely listeria which causes listeriosis. These organisms develop much more slowly than salmonella, multiply in refrigerators (with an incubation period of up to a month), are much more resistive to heat, and have a much higher (30%) death rate. Unfortunately, the procedure of cooking food, then rapidly chilling it in order to be reheated later, used widely in the mass feeding business (not only in human services but also by airlines and similar enterprises) is particularly favorable to the development of the listeria organism.

*There have also been outbreaks of E. coli, due to the development of more virulent strains thereof. Already vulnerable people are always more likely to be the victims.

Issues of Mortality of Mentally Retarded People

There has been a relatively large number of research studies on the mortality and life expectancy of mentally retarded persons. Some such studies have been based on very large samples, including one that had more than 100,000 people (AJMR, 5/96). As far as we know, without exception, these studies have explicitly assumed that the typically lower life expectancies of retarded persons were largely inherent in the health impairments that commonly accompany mental retardation, and especially some of its well-known clinical syndromes. What does not appear to have been done as yet is to relate life expectancies of retarded persons to the life conditions that are afforded to them. In other words, all sorts of deathmaking influences may have been exerted upon the lives of retarded people that brought about lowered lifespans, but these lowered expectancies

were attributed mostly to mental retardation and its concommitants, rather than to external and preventable forces.

For instance, when lifespans of severely retarded persons lengthened--especially in and after the 1950s--this was attributed to the advent of antibiotics, new operations (e.g., for hydrocephaly), new immunization regimens, the decline in TB in the general population, etc. What was virtually never heard was that the improvement in public attitudes contributed to a whole new way of looking at retarded people, and treating them--e.g., in social ways--that reduced all sorts of dynamics that would be deathmaking even when the best health provisions are available.

However, death rates of retarded people must always be expected to be above normal, for many reasons. For instance, over the last 10 years or so, we have noted a steady stream of violent killings (and sometimes of sexual or other assaults) of people just in the greater Syracuse area, who were described in the local newspapers (of which we have collected a large number of relevant clippings) in language that informs us, or strongly suggests, that they were mentally retarded. Sometimes, this information was explicit, sometimes not. Virtually all the victims are from the lower social and marginal classes, and have led troubled lives. The killers are often from the same kind of milieu. Apparently, no one is keeping a count of this, and the same thing is apparently happening elsewhere. Thus it is that extrapolated to the country as a whole, a small army of retarded people can be made dead without anyone seeing the overall picture--and this is merely one of many such hidden causes of deathmaking of devalued people!

Also of relevance to this issue is a study by Kastner, Nathanson and Friedman (1993). It found that among mentally retarded people, mortality rates are much higher than in the general population, ranging from an estimated 1.7 times higher among mildly retarded persons to 4.1 times among the severely retarded (Kastner, Nathanson & Friedman, 1993). It does not seem plausible that these high rates would all be "natural" and expectable even under the best of circumstances.

Another study (Strauss & Kastner, 1996) reported that their research had found that the mortality risks of mentally retarded persons were 72% higher in community settings than in mental retardation institutions. This was not surprising to us because the TIPS editor had been saying for years that the deathmaking of retarded people had increased so much that public mental retardation institutions were now safer places for retarded people than most other service settings, and even family homes (e.g., Wolfensberger, 1991, 1994a).

However, we were chagrined at two things in the article.

1. The authors failed to cite any of the literature that had warned of, or documented, the deathmaking menace, including 13 publications on the issue by Wolfensberger since 1980, many in prominent outlets, including the very journal in which Strauss and Kastner published, and its sister journal (Mental Retardation) published by the same organization, the American Association on Mental Retardation.

2. Much more serious is that the authors presented the data in a way that implied, and was probably meant to be read as, an argument in support of institutionalization.

In the community, mentally retarded people are exposed to both greater opportunities and greater risks. What is urgently needed is that these risks be better acknowledged in our professional community and in those parental and other circles that interpret only the benefits of community living but not its risks and even atrocities. While the professional community is limited in what it can--or is even willing to--contribute to changing the normative realities of a decadent and collapsing society that is such a danger to its weaker members, it is in a position to do vastly more than it has been doing to acknowledge the shortcomings in the human service sector that contribute so much to the plight of mentally retarded persons--both in the community and in institutions of all kinds.

Wolfensberger has long taught (e.g., in public presentations, but also in print, such as Wolfensberger & Zauha, 1973, and most recently in Wolfensberger, 1995) that mentally impaired people need to have competent, active protectors on their behalf, and especially volunteer individual advocates who are not part of the service system; and that as handicapped people move out of institutions into the community, in certain respects this need would be increased, not lessened, because of the greater challenges and complexities that such people would have when living in the community. While many people did take up this idea, promote it, and implement it, resulting in often very inspiring stories (e.g., Stephenson, 1983), a lot of other people did not, including many

professionals, service designers and administrators, and advocates of community living for handicapped people. In fact, some of these parties have been arguing that handicapped people should be independent of the control, supervision, or assistance of competent other parties, and should be absolutely "self-determining" and "self-advocating" about anything and everything regardless of degree of mental impairment. For example, in 1990, The ARC said, "...The ARC is committed to securing for all people with mental retardation the opportunity to choose and realize their goals of where and how they learn, live, work and play" (ARC mission statement, 1990; emphasis added). This phrasing clearly implies that all retarded people are able to choose where and how they learn, live, work and play, and that The ARC would lend itself to enabling retarded people to make these "choices," regardless of how unwise, unwholesome, and even life-endangering these might be. And the Association for Persons with Severe Handicaps (TASH) in 1989 passed a resolution that "...TASH affirms the right of persons with severe handicaps to freedom of choice in all types of settings..." (Executive board..., 1989). A 1991 editorial in the journal Mental Retardation made the following statement: "The right to make personal choices must be left to the individuals who will live with the choices. Service providers need to assist people with mental retardation and their family members in acquiring the information to make rational decisions" (Ficker-Terrill & Rowitz, 1991). Yet many severely and profoundly retarded people will not be able to make such decisions, and they will not "live with the choices" but die with them. One of the two candidates for office of the presidency of the American Association on Mental Retardation in 1990 issued a similar statement as part of her platform. One gets the impression that all these parties no longer believe that retarded people are retarded. Such mindless and unnuanced policy statements on this issue would de facto deprive retarded people of one of the most needed and helpful protections against their coming to harm when they live in more open circumstances than an institution.

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Miscellaneous Other Points Related to Risks to Health or Life of Vulnerable, Devalued &/or Unwanted People

The Danger of Being Marginalized

*Again and again, we run across vignettes in which people of distinctly devalued societal identity end up dead, but where very few people would recognize the dynamics of deathmaking at work.

For instance, in Syracuse alone, there has been a steady trickle of publicity over the years of mentally retarded or mentally disordered people burning to death in fires in the community. Some of these fires were arson, and thus come close to murder in that the arsonist must certainly have reckoned with the possibility of somebody getting badly hurt. In a significant proportion of such instances, the fire had been set by yet another societally devalued and mentally handicapped person, or someone with a long record of criminal behavior. Often, these kinds of fires take place in neighborhoods which are already high-crime areas and which are inadequately policed, and where there is inadequate follow-up when crimes are committed. In other words, the same crime committed in a privileged neighborhood might be followed up much more intensively and earnestly than if committed in low-value neighborhoods, such as slums.

In yet other instances, fires have resulted from accidents caused by people who are simply not competent enough to live independently in the kinds of dwellings available to them. Such accidents might not have occurred had they lived in a supervised context, or received more or better training in homemaking.

Relevant to all the above is that so often, mentally handicapped people live in the type of community dwelling that is only one step above homelessness, and is a firetrap even if arson were not an issue. Thus, it is their extremely low social status which has forced them into these types of dwellings and thereby dramatically increased their risk of dying from fire from whatever cause.

The above are only three examples of very indirect ways in which society gets rid of its unwanted people.

*One population sector in the US that has a very high death rate is that of immigrants from poor countries, particularly illegal immigrants who can disappear without much notice being taken by anybody.

*Evidence continues to accumulate, and in fact seems to be rather compelling now, that lonely people do not live as long as those who have significant social relationships (Science, 29/7/88). Regardless of age, sex, or social class, loneliness is more likely to increase the death rate than smoking, drinking, over-eating, or lack of exercise. Let us keep in mind that one of the big contributors to loneliness is rejection. So whatever marginalizes people socially, and thereby separates them socially, is apt to be deathmaking.

*The 1996 edition of Social Trends, which the newspaper called "the Bible of official social statistics" in England, reported that for decades, death rates had been higher among unemployed men in comparison to all men of working age. A 1990 analysis showed death rates 37% higher than average among men who were out of work during the period 1971 to 1991. The same 1996 report also claims that unemployment is "a major factor" in mental disorders (Guardian, 25 January 96).

*In several countries, it has happened in recent years that elderly all-alone people got entombed in their dwellings. E.g., a pensioner in England was entombed in 1995 when everyone assumed his apartment was empty, and it was boarded up.

*The difference in the life expectancies of "whites" and "blacks" in the US has been widening in recent years. By 1990, it had reached seven years in favor of "whites," which on a population basis is a big whopper.

*Australian aboriginals have death rates which in some age groups are ten times higher than the rest of the Australian population. Among the many reasons is that the aboriginals incorporate the very worst elements of European diets with some of their own dietary customs, leading to a life-time pattern of poor nutrition (Age, 27/7/89).

*While in many parts of the world, there has been an increase in equality, opportunities, and justice for women, in some parts, female identity has become increasingly devalued. For instance, in India, the bias against having daughters (reported above) has been increasing considerably just in recent years, and has spread to all ranks of society. This has resulted in apparently much more deathmaking not only of female children, but also female adults (Smithsonian, 6/93). This should not be surprising in that it reflects the straightforward psychological principle of response generalization. Also, many thousands of women are killed outright every year (often burned) by their husbands or in-laws over demands for larger dowries, or in order for the man to be able to marry again and get another dowry. All sectors of society appear to collude in this practice, including women themselves, such as those of the in-law families. These killings, called dowry deaths, are believed to number in the tens of thousands in India, and of course further reduce the male-to-female ratio. Some authorities attribute this trend to increased consumerism. However, only a small proportion of these killings is officially reported. Corruption in Indian society is said to be so widespread that hospitals, the police and the courts are all being paid off to cover up these deaths. Perhaps India's continued commitment to nuclear weaponry is a fruit of all this deathmaking. Only a few decades ago, everything that was Indian was painted with the rosiest brush by circles that we have now learned to call PC.

Dangers From Poverty & Homelessness

*In both our "wounds" presentation at SRV workshops, and our sanctity of life workshops, we note that the poor have a much higher risk of early death. According to a study reported in 1998 in the Journal of the American Med. Assoc., it is poverty itself, and the stresses of life that are associated with it, that actually contribute to the higher death rate of the poor, rather than any "lifestyle factors" such as smoking or drinking. According to the study, Americans with incomes lower than $10,000 a year had a death rate 3.22 times that of people making $30,000 or more, and people making between $10-29,000 a year had a death rate 2.34 times that of the people in the $30,000+ income range. (Indianapolis Star, 3 June 98; source item from Joe Osburn.)

*In NY State, 17% of elderly people are not getting enough to eat (AP in SHJ, 30/11/93). That's one way to make them dead.

*In Britain, an estimated 3,500 elderly people die during every winter month because they cannot afford to heat their homes (Daily Mirror, 11 Feb. 91, in Speak Out, 2/91).

*In Atlanta, homeless people have been hired on a daily basis to remove asbestos insulation (Hospitality, Spring 91).

Risks From Frailty or Dependency Interacting With Other Factors

*In the Summer 1995 heat wave in Chicago, 457 died from the heat, most of them elderly or otherwise vulnerable people. Most of them were living in poor areas of the city, alone in small older homes, without air conditioning. Many of them, weakened by age or illness, were not aware that they were getting dehydrated. Even though the forecast had warned of dangerously hot weather, the city failed to declare a heat emergency which would probably have prevented many of the deaths. Ambulances ran hours behind, and the bodies were coming in so rapidly that the city morgue ran out of space and had to bring in refrigeration trucks (AP in SHJ, 18/7/95). This is a good example of how an inconvenience to most people can become a deadly menace to vulnerable and marginal ones. It also illustrates imperiality, which does not want to admit that it is not in total control of

everything, including the weather. The mayor said, "We all have our little problems; let's not blow it out of proportion" (Time, 31/7/95). Similar heat death waves have occurred in many other US cities. Because the masonry of cities retains heat at night, city people are more affected than rural ones.

Heat waves are always dangerous for elderly people, but can be aggravated by societal collapse. After her husband was put in a nursing home, an elderly woman in Indiana was too afraid to open her windows or doors, and consequently died of the heat (AP in SHJ, 23/8/95).

*Eyman, R. K., Call, T. L., & White, J. F. (1991). Life expectancy of persons with Down syndrome. American Journal on Mental Retardation, 95(6), 603-612. A growing body of literature in the area of mental retardation and related impairments has begun to point to impaired mobility and impaired capacity to eat independently as grave threats to a person's life expectancy. In fact, in some instances, lack of competencies in these two domains has been found to be more debilitating than the presence of significant health problems, even though the conventional wisdom of the past had been that it was these other health problems that abbreviated the lives of handicapped people.

*A handicapped woman dependent on aides wrote that people "who need human and technological assistance to survive..are already on death row...we are too beaten and confused to appeal the execution, and society won't even provide funds for an aide to feed us our last meal" (Update, 2/91).

Prison Deaths

*The varieties of deathmaking in prison are absolutely amazing. E.g., in US federal prisons, many prisoners arrive already sick, but their medical record does not come with them. Some who are epileptic do not receive their seizure medication. During the interminable transfers of prisoners from one prison to another, sometimes in buses, sick prisoners may spend days on these buses before being attended to. The major federal prison hospital in Springfield, Ill., is informally referred to as a death house by the prisoners. Prison physicians are often unlicensed.

#30 Perversion alert A massive new form of deathmaking is rapidly in the ascendancy. It is the increase in prison crowding even as TB is beginning to run rampant in prisons. We could soon see the prison equivalent of the die-off seen in the male homosexual population. But even more than with AIDS, those who would be indifferent to, or even welcome, the prison die-off will, in the long run, run a high risk of becoming TB victims themselves.

*The death of a 29-year-old mentally retarded prisoner in Pennsylvania's Camp Hill Prison has created an uproar. Hard as it is to believe, the man died from dehydration after having been 11 days in the prison infirmary! The prison authorities blamed the medical staff, but it was the prison guards who had prevented the medical staff access to the patient or had made false entries into the man's medical chart (Philadelphia Inquirer, 26/1/93; source item from Margaret Sager).

*Something very close to observing somebody to death occurred in the Syracuse jail in 3/96 when a drug-addicted woman was brought in and spent the night in agony and pain, with physicians, licensed practical nurses and registered nurses periodically examining her, but doing nothing but giving her laxatives until she collapsed into a coma 16 hours later and was taken off life supports 3 days later. It was discovered that she died from the rupture of an ectopic pregnancy.

*A physician at the Huntsville (Texas) prison supervised the technicians who executed prisoners in 1989. In 9/90, three physicians played an active role in killing a condemned murderer for the state of Illinois (CRTIR, Spring 1991).

Unclassified Items Related to Deathmaking

*Even though the founding fathers of the American republic were Enlightenment people, they still deeply held to traditional Christian values. They obviously still believed in the absolute and intrinsic value of human life as pronounced by Judaism and Christianity, because they defined the right to life as an "inalienable right," at least in the Declaration of Independence. It is therefore also ironic that in recent decades, at the very time when government has created innumerable new rights, it has taken away the most basic right of all and has even changed the definition of humanhood through a cynical manipulation of the construct of personhood.

*For a long time, tobacco advertisements have been targeting children, youth, and stupid people. Newsweek (20/11/95) called tobacco companies "the rabid raccoons of corporate litigation."

*Some of the economic benefits to society of various kinds of deathmaking can be rather subtle. For instance, one often hears about the financial cost of smoking to society, but according to at least one study, smoking actually saves society money by killing off people at an early age. While each package of cigarettes costs society an average of $.55 in eventual medical care, and drives up life insurance premiums by $.14, it saves Americans $1.19 in pension and Social Security payments, and $.22 in nursing home expenses (Newsweek, 12/94). It is thus very gratifying to note that the stupid young people of today are taking up smoking in vast numbers.

*For years, unscrupulous drug manufacturers, both in the Western and Third World, have been selling phony medicinal drugs (some of them inert, and some of them outright poisonous) in the Third World, as a result of which there have been large numbers of deaths (CBS TV "60 Minutes," 18/1/98).

*A six-year old girl who understood that her mother was dying of AIDS deliberately committed suicide by stepping in front of a fast-moving train in Florida (SHJ, 16/6/93). What is amazing is that people who defiantly engage in irresponsible sexual habits disavow all responsibility for the indirect tragedies of which they are causes. A man gets AIDS from having sex with thousands of other men, one of whom gives it to another man who has sex with thousands, who gives it to another man, who has sex with hundreds, who gives it to a woman whose child commits suicide--and no one is at fault, according to PC dogma, or at most somebody along the line gets blamed for not using condoms against STD transmission, which would be only partially effective at best anyway. The situation is similar to that of a NY City child of 4 who found her drug-addicted father's methadone in the ice box, drank it, and died (SHJ, 11 March 94).

*How successful ambulance crews are in saving their patients' lives depends in good part on how much traffic they encounter on the way to the hospital, and to what degree other motorists are willing to give ambulances the right-of-way. For instance, in Seattle, 15-35% of people with a cardiac arrest will be gotten to the hospital in time to live, but in New York City, only 5% will. Another factor is whether bystanders will start resuscitation when a person has a heart attack. In New York City, people will walk right by and over someone who drops with a heart attack, and motorists will not yield to emergency vehicles, showing how far the fabrics that make for a viable polis have collapsed there (Discover, 11/95). In fact, in some New York City neighborhoods, ambulances are greeted with sniper fire, and sometimes, motorists will run over a paramedic who is helping an accident victim.

*A woman wanted to present a baby to her boyfriend, but when she had a stillbirth she invited another young woman with a new baby over to her house, murdered and burned the mother, and pretended that the baby was her own, all this with the help of her own 13-year-old daughter (AP in SHJ, 20/3/91). Since killing is increasingly the way to get what one wants in this society, one

should not be surprised that people would either kill to get a baby they want, or kill their baby to get something else that they want.

*In many medical schools, medical students used to hold a memorial service every year for the people on whose cadavers they learned anatomy. These kinds of services were an expression of gratitude, and a shoring-up of respect for the human body. Nowadays, such services are being explained as efforts "to help students deal with death and dying" (SPS, 6 Aug. 96).

*Part of the German mental institution Sonnenstein in Saxony, where 15,000 mentally handicapped people were put to death in 1940-41, is once again a sheltered workshop for handicapped people. The rest of the facility has been sold for business use (5/98 source information from Carsten Krüger).

*Leslie Fiedler, the author of the well-selling 1978 book Freaks: Myths and Images of the Secret Self, said in his 1996 book, Tyranny of the Normal, that calling people with "drastic difficulties in ambulation" "challenged," or even "disabled," is an easy way of appeasing one's guilt over one's instinctive tendency to call them "cripples" and similar terms. He also claims that if people are not afforded legitimate and ritualized means of "abusing" the young, then generational conflict will erupt in murderous form.

*How much depersonalization can facilitate deathmaking is underlined by the fact that vastly more people support the death penalty in the abstract than are willing to see it imposed on a specific individual who they know by name, by face, and in terms of that person's human frailties. Suddenly, they see themselves at least a bit in that other person, and are willing to make exceptions to the abstractions which they otherwise, and still, voice. This phenomenon accounts for the reluctance of juries to impose death sentences even when they have no moral objections to them in principle (Newsweek, 7 Aug. 95). Obviously, a huge implication here is that when someone is at risk of being subjected to deathmaking dynamics, it is of the greatest importance to personalize that individual to those people who would otherwise contribute to the deathmaking. The tactical measures to implement this strategy are legion. For instance, in our guideline on how to protect vulnerable patients from being made dead in hospitals (covered above in this issue), we point to such small measures as posting photographs of the patient that show the person in an unimpaired fashion and in positive juxtapositions and relationships. Attending personnel--such as nurses--are almost always positively affected by this.

*We do not want to convey the message that handicapped people are always the victims of abuse and deathmaking, and never the perpetrators thereof. We also run across a lot of reports of mentally limited people committing violence and arson; and in some cases, it is a mentally retarded person who inflicts deadly violence on another mentally retarded person so that one of them ends up dead and the other one in prison. (Some such vignettes were covered in earlier sections.) At least a fair proportion of these acts of violence (or other troubles) are the result of retarded people who are incapable of adaptive independent functioning having been dumped/abandoned by society and its service system without the necessary supports, usually in the name of normalization, deinstitutionalization, liberation, rights, independence, self-determination, advocacy, self-advocacy, empowerment, choice, giving the person what he or she wants, etc.

Other Issues of Utilitarianism of Deathmaking

*The cover story of Newsweek of 18/9/95 was devoted to the forecast that elderly people were becoming ever more expensive while contributing little productivity.

*A severely physically handicapped man in Germany wrote a very powerful article documenting the wounds in his life. The care that he requires in order to be able to live costs about $16,000 per month, and he asks: "Am I worth that much?" (Die Tageszeitung, 5 May 1997, p. 11).

*Ever parsimonious, the Chinese use the ashes of prisoners who had been condemned to death as fertilizer.

*Some advocates have been trying to obtain very major organ transplant operations for their handicapped advocatees. There are other people who would deny such transplants to handicapped persons, and whatever the stated arguments are, fundamentally on account of their devaluation of such persons. On the other hand, there are advocates who are almost talking as if handicapped persons should be entitled to a transplant because they are handicapped, and that criteria otherwise applied to non-handicapped people should be overridden. Both positions are of course faulty extremes. While our overall stance is one of deep skepticism of the transplant culture, and while we have been warning people of its profound interdigitation with deathmaking practices, we can point to at least a few elementary criteria for those cases in which a transplant is considered at all. The judgment of the merits of the case should be based heavily on the likely success of the transplant in purely medical terms, rather than social evaluation or peculiar judgments of "quality of life." But other things to be considered are whether a handicapped person is likely to be able to really cope with the immense stresses of the transplant process, and whether there is enough structure and supervision in a person's life to assure that the necessary follow-up and regimens are likely to be observed. It would be absurd to deny a person with good prospects an organ and instead give it to a mentally handicapped person who subsequently is given "self-determination," and the "right to choose" not to adhere to the disciplines necessary to make the transplant work. For instance, where a liver transplant is at issue, a person with a drinking record who is very likely to engage in alcoholism after a transplant should be considered a much poorer prospect than one in which there is no reason to suspect this.

*An artist, who formerly worked as a butcher and in a slaughterhouse, uses parts of human bodies in his work, mostly making casts of them. He was arrested in April 1997. He claimed to have acquired the body parts from medical schools and kept them in his refrigerated studio outside of London (Guardian, 10 April 97).

Deathmaking-Related Resources

*Clowes, B. (1994). The pro-life activist's encyclopedia. Stafford, VA: American Life League. Said to be a source on every imaginable data on deathmaking and life defense. The $99 price is not exorbitant considering there are 1,670 pages.

*The TI publication entitled The New Genocide of Handicapped and Afflicted People is a very condensed statement of the kind of material that the TI offers in its 4-day workshop on the sanctity of life. It has lost none of its relevance since the publication of its second edition in 1992. However, it is becoming clearer by the day that modernistic society has made an identity alliance with death and is determined to legalize all sorts of forms of "euthanasia," on top of the other forms of deathmaking that it had earlier legitimized or legalized. In our opinion, this accounts for the fact that very few people are interested anymore in being exposed to any systematic position in defense of the lives of societally devalued people, and that this in turn explains why there has been a dramatic drop-off in the sales of the above-mentioned monograph since spring of 1996. In fact, sales have plummeted to next to nothing. We urge our readers to promote this monograph actively and on an ongoing basis. It sells for a mere $8.00 plus S&H, with sizable discounts for quantities above nine.

*Santos, J. F., & Walker, V. R. (Eds). (1993.) Bibliographies in psychology: Elders at Risk: Abstracts of the psychological and behavioral literature on elder abuse, victimization, and suicide. Washington, DC: American Psychological Association. This book contains citations or abstracts of 29 relevant books, 41 dissertations, 126 chapters and 546 articles.

*MacLean, A. (1993). The elimination of morality: Reflections on utilitarianism and bioethics. New York: Routledge. This book has considerable concordance with our teaching on the sanctity of life issue, though it seems to give utilitarianism more weight than we would. It also argues, much as we do, that the current bioethics culture is in effect dishonest.

*Friedlander, H. (1995). The origins of Nazi genocide: From euthanasia to the final solution. North Carolina: University of North Carolina Press. Here is the modernistic mind at work once again: nothing is connected to anything else. The author disavows any connections between the Nazi killing of the handicapped and the killing of today's unwanted born and unborn children, and no such thing as a slippery slope is acknowledged.

*Arluke, A., & Sanders, C. R. (1996). Boundary work in Nazi Germany. In Regarding animals (pp. 132-166). Philadelphia, PA: Temple University Press. This chapter documents yet another of the innumerable parallels between the deathmakings by the Nazis (of the handicapped, Jews, and other devalued groups) and those on the contemporary scene. Namely, much as there are more and more people every day who dispute that there is a qualitative difference between animals and humans, and argue that some animals are more valuable than some humans, so did the Nazis attempt to deny this distinction, claiming that it was an invention of religion. Accordingly, it was easy for them to talk about certain humans having the status of Tiermensch, i.e., an animal human (source item submitted by David Goode).

*de Mildt, D. (1996). In the name of the people: Perpetrators of genocide in the reflection of their post-war prosecution in West Germany. The Hague, Netherlands: Martinus Nijhoff. This book is the first major work to systematically document the connection between the killing of handicapped people in Nazi Germany and the killing of the Jews, focusing narrowly on members of the medical and human service professions. It documents how many of the physicians involved in the killing of the handicapped ended up working in some capacity in concentration camps killing Jews.

*Holodnak, M. F. (1983). Footsteps to survival. New York: Philosophical Library. Though written years ago, this documentation and analysis of the atrocious conditions in US veterans' hospitals is probably still valid.

*Hoyt, J. D. (1996). A gentle approach: Interacting with a person who is semi-conscious or presumed in coma. Issues in Law & Medicine, 12(1), 7-78. (Reprinted from Working Papers in Law, Medicine and Philosophy, No. 2, Program in Human Rights and Medicine, J. M. Dolan, Series Ed., 1994. Minneapolis: University of Minnesota) This is an excellent set of 38 guidelines on how to interact with someone who is in a coma or other state of severe impairment of consciousness. The guidelines are designed to elicit as much consciousness and/or interaction from the patient as possible, and to combat deathmaking by others.

Postscript from the TIPS Proof-Reader

Even though a proof-reader is supposed to attend just to spelling, grammar, and punctuation, it is hard not to read the content as well. On the one hand, the totality of 90+ pages of deathmaking is so overwhelming, one wants to retreat from the world and all its horrors entirely. On the other hand, almost every individual item is arresting in its own way, and one could meditate for a long time on what each one means and what must be behind it.

New SRV Resource

Since 6/98, there has been available the REVISED 3rd EDITION of the SRV monograph, entitled A Brief Introduction to Social Role Valorization: A High-Order Concept for Addressing the Plight of Societally Devalued People, and for Structuring Human Services. The SRV monograph

was first published in 1991, with a 2nd edition in 1992. This 3rd edition is revised and greatly expanded (139 pages, vs. 80 pages in the previous edition). It contains much new material on the power of social roles, the benefits of valued roles, guidelines for applying SRV in specific situations and with specific persons, as well as coverage of the most common wounds of devalued people and their implications. The monograph contains all the earlier material on social devaluation, image and competency enhancement, and the "themes" of SRV, but all this has been improved, and the themes material has been greatly expanded, with the addition of three more themes. The cost of this edition is $14 US, plus shipping and handling (15% to US addresses, 20% to all others; minimum $2). Quantities are discounted as follows: 15 to 24 copies 15%, 25 to 49 copies 22%, 50 or more copies 30% discount. For more information, or to order, contact the Training Institute (see letterhead for address). Parties in Australia and New Zealand must get prices and copies from John Annison, Deakin University, School of Studies in Disability, 221 Burwood Highway, Burwood, Victoria 3125, Australia. In the British Isles, contact Rob Henstock, The Poplars, 112 Stamford St., Stalybridge, Cheshire SK15 1LU, England; phone/fax 01 61-303-9040.

Old SRV Resource Again Available

PASSING Checklists, Scoresheet/Overall Service Performance forms, and Subscores Computation forms are now once again available for purchase from the Training Institute. The forms contain corrections over the forms that were published in 1983 when the 2nd (current) edition of PASSING came out. The Training Institute is selling the forms in a package, currently consisting of 100 copies of each form, plus four copies of the Team Leader Checklist, for $56.00.

The Training Institute also sells the PASS 3 Handbook and Field Manual, and the Checklists and Scoresheets for PASS. The Handbook and Field Manual are sold together as a set for $25 per set, $20 per set for 25-49 copies, and $18 per set for 50 or more copies. The Checklists cost $15 for 100 copies, and the Scoresheets $12 for 100 copies.

People in the United Kingdom can purchase the PASS 3 books (though not the forms) from Rob Henstock, The Poplars, 112 Stamford St., Stalybridge, Cheshire SK15 lLU, England; phone/fax 01 61-303-9040.

Please remember that it is illegal and unethical to copy copyrighted forms. Orders can be placed by contacting the Book Manager at the Training Institute, 230 Euclid Ave., Syracuse, NY 13244-5130, phone 315/443-4264.

Miscellaneous News Related to Human Services & Health

*In late 1997, Germany signed a reconciliation accord with the Czech Republic that would pay for the construction and operation of old-age institutions for 8,500 survivors of the Holocaust--a most bizarre image of transinstitutionalization from a concentration camp to a nursing home (Boston Globe, 24/12/97; source item from Marc Tumeinski).

*According to some estimates, more than 50% of Americans die in hospitals, and about another 20% in nursing homes (APA Monitor, 4/97).

*According to The Oldie (2/98, p. 10), 65% of people in the UK currently die in hospital, and only 25% of them at home. The rest die either on the street, in some other public place, or in hospices. Similar figures would probably hold true for the rest of the western world.

*The US government began to require that every death in a hospital be reported by it to local organizations that try to procure organs, on penalty of losing Medicare subsidies (AP in SHJ, 18/6/98).

*Nursing homes have been found to be one of the most hated things by Americans, ranking roughly equal with the IRS (tax agency). Juror sympathy with plaintiffs against nursing homes has

led, and is predicted to continue to lead, to many big money award, mostly to family members rather than victims (Newsweek, 27/7/98).

*It is amazing that immediately upon coming on the market, the very expensive male sexual potency drug Viagra was approved by health insurance corporations for reimbursement under their medical service coverage plans, immediately eliciting a flood of demands that contraceptive drugs be similarly covered. One women's health practitioner said that contraceptive drugs are a "medical necessity for women during 30 years of their lifespan" (NC Register, 5/98). Some experts have predicted such a demand for Viagra that if insurance coverage continues to be widely granted, insurance premiums would have to be very significantly raised.

*Scientists are confident that they have shown that Tamoxifen can prevent the onset of breast cancer in women. The problem is that 3 million women in the US aged 35-59 may fit the high-risk profile, which could be a PPP bonanza for the drug and health services field (Science, 10 April 98).

*It has been estimated that 4 million Americans have hepatitis C, that about a quarter of them do not know it, and because the disease destroys the liver, they may all be lining up for liver transplants. Hundreds of thousands may have acquired the virus from blood transfusions prior to 1992, and many others caught the virus from features of their decadent lifestyles, explaining why infection is vastly higher among prisoners and drug-users. Deaths from the disease may overtake AIDS within 20 years (SHJ, 18/3/98).

*Australian teenagers are found to have an amazing array of health problems and high death rates from road accidents, firearm injuries, eating disorders, suicide and skin cancer from irresponsible exposure to the sun--all this despite intense anti-cancer campaigns, which show how limited the effect of certain kinds of "education" can be (Sunday Mail, 20/7/97).

*A top executive of one of the largest hospital chains in the US was indicted in 8/97 for fraudulent billing of the government (mostly of Medicare) (Newsweek, 11 Aug. 97).

*A Miami nightclub owner with no health care experience set himself up as a Medicare service provider and stole $32 million from Medicare. He testified before a US Senate Committee that he knows of no other business where one can make as much money as easily with as little risk (AP in SHJ, 30/1/98).

*A 1993 book entitled Medicine, Money and Morals claims that medicine has become increasingly enmeshed in a web of conflicts of interests of epidemic proportions, profoundly distorting the commitment of physicians to their patients. The author notes that the law profession is light years ahead of the medical one in identifying, acknowledging, and dealing with conflicts of interest.

*Greene Valley Developmental Center is an institution for (until recently) about 800 mentally retarded people in East Tennessee. We were startled to read in its newsletter that in 1990 alone, 33 employees saved various clients' lives in emergency situations. This is commendable, but also suggests an extraordinarily high risk status of the residents.

*Dyer, W.W., & Dyer, M. (1996). A promise is a promise: An almost unbelievable story of a mother's unconditional love and what it can teach us. Carlsbad, CA: Hay House. This short book (90 pages) tells some of the story of Kaye O'Bara and her daughter Edwarda who has been in a coma since 1970. The story is very simple: when Edwarda went into a diabetic coma in 1970 at age 17, Mrs. O'Bara began to take care of her at home, first with her husband's help, and then after he died, mostly on her own. Her daughter is believed to be the person who has survived the longest in a coma. Her care requires tube feeding every 2 hours, and blood testing and insulin injections every 4 hours, not to mention bathing, turning, grooming, and suctioning since she cannot swallow.

This Mrs. O'Bara has done faithfully since 1970, her only break being a 10-day stretch when she had a heart attack and was in the hospital. The physician who takes care of Edwarda has been donating his services for free all these years, and some family members and friends also help on a frequent regular basis. There is also a nurse's aide who helps out for a few hours a few days each week. Edwarda has made some progress in eye and hand control, and appears to make some sounds, and to cry and laugh, which may indicate some awareness of what is going on around her. Mrs. O'Bara firmly believes that Edwarda will someday fully recover.

The story in its simplicity is at once so heroic as to be almost unbelievable, as the subtitle of the book states; but also so instructive and inspiring about what it is possible to do where deep love, positive valuation, and faith are present. Mrs. O'Bara has apparently never wavered in any of these three; she promised her daughter just before the latter slipped into the coma that she would never leave her, and so she hasn't.

The book is filled with little passages and vignettes relevant to the social role-valorization of even such very profoundly impaired people as Edwarda. For instance, her mother keeps her impeccably clean, groomed, and well-dressed, and the bedroom contains not only all the medical supplies and equipment, but also family pictures and religious items (the O'Baras are devout Catholics). Mrs. O'Bara has fired every doctor who ever said that if it were his daughter, he would put her in an institution. Even though her daughter is nourished by tube, and presumably therefore does not taste what she eats, Mrs. O'Bara nonetheless prepares her daughter's favorite foods, reads and talks to her daughter all the time, and has tried to keep her "up-to-date" on the many kinds of popular music that have arisen since 1970, as well as all the new TV shows.

The book is quite clear that what sustains Mrs. O'Bara in this commitment is her deep faith in God, and a devotion to Mary, the mother of Jesus; this might put off some readers while it will appeal to others.

There are 14 photographs of the family in various stages of Edwarda's growth and condition.

The person who did most of the actual writing is Wayne Dyer, better know for some pop psychology books such as Your Erroneous Zones. He wrote the book to both publicize the O'Baras' story, and help Mrs. O'Bara with her crushing debt: the insurance coverage ran out only 6 years into the coma, and Mrs. O'Bara has been taking care of her daughter at home with a meager monthly Social Security check, no other help from the government (Medicaid would only pay if she put Edwarda in a nursing home), donations from friends and supporters, and by remortgaging her house many times over and taking out loan after loan--including once from a mob loan shark! Therefore all the royalties from the book go to Mrs. O'Bara .

The best parts of the book are actually the passages in which Mrs. O'Bara speaks in her own very simple and direct way. But at the end of each chapter, the author spells out some lessons that he thinks can be drawn from the story for readers to apply in their own lives.

However, there are several shortcomings of the book.

1. Dyer and his wife both write in an almost fawning tone that suggests a super-human quality to Mrs. O'Bara and her daughter. For instance, Edwarda is interpreted as having been a perfect child who never wronged another creature, and the words saintly and saintliness appear many times. It may well be true that both Mrs. O'Bara and her daughter are saintly--in fact, we can easily believe it--but the tone may actually convey to readers that unless one is of their caliber, one could not do what Mrs. O'Bara has been doing. Also, Dyer's wife writes very fawningly of him and their own children.

2. Perhaps in an attempt to make the story appeal to a wide readership, Dyer talks about God in most peculiar terms. He is quite clear that Mrs. O'Bara's faith is Catholic--he refers to her conversations with Mary as "apparitions of the Blessed Virgin," as Mrs. O'Bara believes them to be--yet speaks about God as "life-force," "pure energy," etc.

3. Relatedly, the book also uses a lot of psycho-pop terminology, e.g., "finding your inner spiritual self."

TIPS readers might be interested in obtaining the book just in order to financially support Mrs. O'Bara in her service to her daughter. This book is available for $14. If it is not in bookstores, it can be ordered directly from Hay House, toll-free from within North America at 800/654-5126.