

Women Who Died From Abortion  
Nazi Euthanasia Program  
Elderly Murder-Suicide

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# THE AMERICAN FEMINIST<sup>SM</sup>

Feminists for Life of America<sup>®</sup>

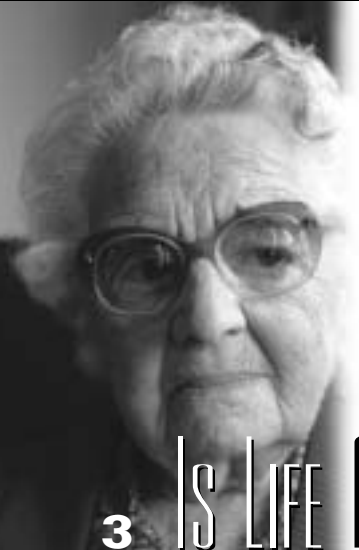


Is  
*Life* always  
worth  
*Living?*

Feminists for Life examines assisted suicide and euthanasia.

# THE AMERICAN FEMINIST

Feminists for Life of America



S U M M E R

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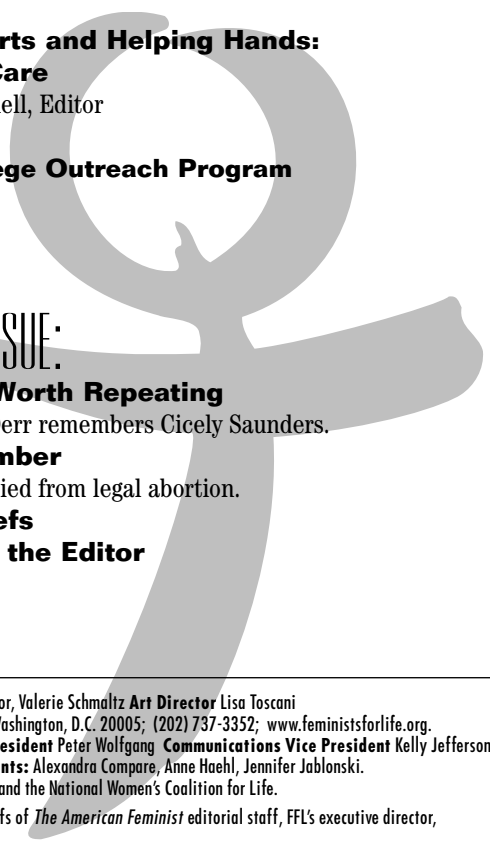
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# Property to Be

# Disposed of

# as Society

# Sees Fit?

**SINCE ROE V. WADE the growing number of abortions has rightfully demanded most of FFL's attention. Shortly thereafter, the death penalty was reinstated, child abuse escalated, violence against women became rampant, and now even infanticide through partial-birth abortion is sanctioned by our nation's president, some judges and some legislators.**

More recently advocates of suicide, assisted suicide and euthanasia have adopted the language and strategies used to mainstream abortion. Once again, women will pay the highest price. Women have already demonstrated their willingness to sacrifice themselves just as they have sacrificed their children for the convenience of others. And like the majority of domestic violence cases, women are the majority of victims in murder-suicides by despairing spouses unable to cope with the stress of caregiving. As women statistically have longer life spans than men, they are the most likely targets of physician-assisted suicide. The majority of euthanasia advocate Dr. Jack Kevorkian's victims have been women. If assisted suicide and euthanasia are sanctioned choices, how many women will feel pressured to choose them?

In 1873 Elizabeth Cady Stanton, a leader of the women's rights movement, wrote: "When we consider that women are treated as property, it is degrading to women that we should treat our children as property to be disposed of as we see fit." The ever-increasing tolerance for euthanasia, assisted suicide and suicide clearly demonstrates that *women* are now property to be disposed of as society sees fit. Pro-life feminists must work to address the root causes that drive women and men to the desperate act of euthanasia, assisted suicide and suicide by replacing suffering and isolation with love and compassion.



Serrin M. Foster  
Executive Director

# A FEMINIST CASE AGAINST ASSISTED SUICIDE



**C**URRENT MOVEMENTS TO LEGALIZE physician-assisted suicide and euthanasia are using some familiar language. Choice. Autonomy. The moral right to control one's own body. In the United States, certain activists, physicians, and ethicists are making a moral argument for one's right to assisted suicide and euthanasia in order to control how and when one dies. Feminists and others must now confront the dilemma of whether this new liberty would contribute to human well-being. More specifically, would women benefit from these additional options at the end of life?

Women have for so long been denied full autonomy and respect in our society that it might be tempting for feminists to endorse a social measure that claims to increase women's freedom of choice. But feminists have learned to be cautious when new social or medical interventions are on offer. Proposals, which initially look positive, can result in unforeseen drawbacks and dangerous side effects—especially when medical technologies are involved. One only has to think of ongoing debates surrounding abortion, reproductive technologies, and hormonal therapies, to name but a few. Is there any consensus to be found among feminists, and if so, what would characterize a feminist critique of assisted suicide and euthanasia?

**Women will be affected more directly by the euthanasia debate, simply by virtue of the fact that women live longer than men and in their old age command fewer financial and social resources.** In a sexist society that also suffers from ageism or prejudice and discrimination against the old, more women will end up living alone as fragile persons in need of care. As families become smaller and more dispersed, many women, particularly single, childless women, will not have nearby kin who can care for them or serve as their advocates within increasingly complex health-care systems.

When the option or choice to end a life is morally permitted, the interpersonal situation changes. One must justify her or his choice to go on living, particularly when one is dependent upon others to some degree. Subtle pressures can all too easily emerge, pushing a person to stop being a burden on others by taking up resources and energy.

**Women who have been socialized to be self-sacrificing may be the most vulnerable to such pressures.** It is relevant to note that most of Dr. Jack Kevorkian's clients who have used his assisted-suicide machine have been women. People request assisted suicide when they are not yet in pain because they fear future debilitation and dependency. Fear of dependency is partly a fear of losing power and self-control, but it can also be a fear that others will not take care of you. To become ill is to enter the land of vulnerability where what you need above all is an unconditional entitlement to receive appropriate care.

Feminists will be pessimistic if they look to the way women have been treated in health-care facilities devoted to birth and reproductive health care, or to the way women on welfare have fared. It is instructive also to look at the way abortion moved from being approved of as a tragic choice in exceptional cases to becoming a routinized necessity with only the most perfunctory of counseling or alternatives offered to women. Individual choices have a way of quickly becoming routine procedures in the larger institutions of society. A quick medicalized technological "solution" to problems can take over.

In our own disorganized, economically stressed, market-driven American health system, with so many of the poor having inadequate health insurance, many abuses could be expected. Little legal supervision or regulation could really be effective. Certain physicians would undoubtedly become known for their willingness to approve suicide and euthanasia requests, and perhaps, as with abortion, special for-profit clinics would be set up. Poor and uninsured old persons—particularly women, minorities and persons with disabilities—would be most at risk.

Do women stand to benefit from the right to assisted suicide and euthanasia? Hardly. In fact, women, once again, would pay the ultimate price. ○



# D SUICIDE AND EUTHANASIA

**Individual choices have a way of  
quickly becoming routine procedures  
in the larger institutions of society.**

Elise Ehrhard



Elderly M  
Die in Ap  
Murder-S

# Elderly Murder-Suicide

*Elderly  
in Appo*

**H**EADLINES LIKE THESE in the newspaper shock and dismay readers, yet such cases have been increasing dramatically in the past decade. Murder-suicide is defined as a case in which an assailant first kills an unaware or unwilling victim, then turns the weapon on him- or herself.

Double suicides are cases where both parties actively plan out their own deaths.

The majority of murder-suicide cases among the elderly involve a severely depressed husband who is caring for a wife with Alzheimer's disease, cancer or other terminal illness. The weapon used is almost always a gun, and there is no evidence that the woman anticipates what is about to occur. Dr. Donna Cohen, director of the University of Southern Florida's Institute on Aging, writes in the *Atlanta Journal and Constitution*: "It is especially distressing that perhaps as many as two-thirds of women do not want to die this way."

It is important to note that the majority of men in these cases, usually in their early to mid-80s, have no history of violence and are consistently described as "kind," "loving" and "devoted" husbands. Why, then, are they perpetrating these crimes?

An analysis of elderly suicide rates overall offers answers to this question. Elderly suicides are cases where the elderly victim kills himself or herself alone and without assistance. Like murder-

suicides, these cases are highest among Caucasian men and usually involve a gun. The elderly have the highest annual suicide rates in the nation, at 17 per 100,000 for those over 65, and 22 per 100,000 for those over 80—compared with 11-12 per 100,000 for the general population. Of that group, elderly men commit four times as many suicides as elderly women. Their methods tend to be more lethal and bloody. Elderly men are more likely to reach for a Colt 45 than sleeping pills.

The U.S. is not alone in these statistics. In Japan, the elderly suicide rate is 17 to 18 per 100,000 per year. In the United Kingdom, elderly suicides accounted for 17 percent of all suicides in 1995. Elderly suicide rates are likely to rise as the baby boom generation ages.

Elderly men tend to have fewer social networks than elderly women and are more likely to suffer the effects of isolation and withdrawal. In addition, men of the World War II generation were brought up in an era when "real men" were not supposed to cry. Therefore, they are less likely to seek out emotional support and assistance when suffering psychological stress. This fact also correlates with men's greater difficulty than women's in coping successfully after a spouse dies. Emotional isolation increases an individual's risk for depression.

In cases of murder-suicide, the pressures of caregiving add even more stress. Notes

left by husbands regularly cite fears over a wife's declining health or an inability to care for her. Often husbands themselves are in failing health. In a recent murder-suicide case in Tampa, Fla., a husband was forced to put locks on the insides of doors to keep his wife, who was in late-stage Alzheimer's, from wandering away.

(According to Cohen, 70 percent of seniors caring for spouses with Alzheimer's become clinically depressed.) In a 1995 case in San Diego, a husband called his family doctor just before turning the gun on himself and told the doctor he could no longer stand to see his wife in such pain, but could not bear the thought of living without her.

Fear of separation from a spouse is another factor in both murder-suicide and double suicide, especially fear of nursing-home placement. For couples who have lived together for 50 or 60 years, the potential for forced separation is a devastating thought. In a 1991 study of elderly suicides, fear of nursing-home placement was the most commonly cited reason for suicide. The fear was strongest among married persons.

Depression among the elderly often goes untreated or undetected for a variety of reasons. Among them is a lack of education about the warning signs, for both medical personnel and families. A scan of murder-suicide articles throughout the country

# Wife's Poor Health Called Motive in Murder-Suicide

## an, Wife parent uicide

### Couple Found Fatally Shot rent Murder-Suicide

reveals that children or loved ones were often visiting or talking with the victims days, or even hours, before the incidents occurred. In hearings before the U.S. Senate Special Committee on Aging, David C. Clark, director of the Center for Suicide Research and Prevention in Chicago, testified that more than half of seniors who commit suicide are living with a family member at the time. Approximately 40 percent see their doctor in the last week of life and 70 percent in the last month.

Clearly then, both medical personnel and families need to learn the warning signs of depression and *the questions that they should ask*. This is especially important in dealing with elderly men, who are less likely to reveal their feelings.

It is important for a physician or relative to ask the elderly person about his or her *overall outlook on life* and listen for whether the person feels a loss of meaning or purpose. Signs of depression include sleeplessness, loss of appetite, social withdrawal, lack of energy, loss of interest, and constipation. If these signs are detected soon enough, intervention can begin before tragedy strikes.

Unfortunately, intervention is often hampered by what Clark describes as an

“insidious ageism” in our society. Many in society, including medical professionals, are focused more on physician-assisted suicide and euthanasia than on nurturing the will to live in elderly patients. A poll conducted for the Geriatric Psychiatric Alliance found that 93 percent of Americans believe “late-life depression” is an inevitable reaction to disease.

The truth is that depression is treatable and curable at age 18 or 80.

Along with active counseling and pharmacology that can successfully treat symptoms of depression, individuals and organizations need to address the causes of the problems elderly spouses and caregivers face. Solutions include finding alternatives to nursing-home placement such as hospice care, regularly monitoring elderly relatives and patients, and, most important, helping elderly persons renew their sense of meaning and purpose within the changing circumstances of their lives.

Our society can greatly reduce the number of tragedies occurring among the elderly today. But first, we must genuinely believe that their lives are indeed worth living. ○



If you need help...

The following organizations provide help and information for those suffering from depression and for their families and friends:

**National Alliance for the Mentally Ill**  
1-800-950-NAMI

**National Institute for Mental Health**  
1-800-421-4211

**National Mental Health Alliance**  
1-800-969-NMHA

**National Foundation for Depressive Illness**  
1-800-248-4344





PHYSICIAN-ASSISTED SUICIDE became a legal option in 1997 for terminally ill patients in Oregon, making it the only jurisdiction in the United States where assisted suicide is legally sanctioned.

The Death with Dignity Act allows terminally ill Oregon residents to obtain prescriptions from their physicians to be used as self-administered, lethal medications. It specifically prohibits euthanasia, where a physician or other person directly administers a medication to end another's life.

The state's health division issued an initial report on the law covering the first year of its implementation. Of 23 people who requested lethal prescriptions, six died from natural causes and two remained alive by the end of the year. The report details the requirements patients and doctors must follow, and the reporting system used to monitor patients and collect information on physician-assisted suicide.

Advocates of assisted suicide claim the report proves all is well. However, a closer reading reveals that many opponents' worries may be justified. A recent study in the *New England Journal of Medicine* raises serious issues about how data were manipulated or excluded.

One concern is that physicians are not required to report assisted suicides to the state—only the writing of all prescriptions for lethal medications. Therefore, there is no reliable data on how many suicides were actually completed.

The study also reports that people who committed suicide had shorter relationships with the doctors who prescribed lethal prescriptions than did a control group of patients who died naturally. **The first woman to commit assisted suicide had a 2 1/2-week relationship with the doctor who wrote her lethal prescription.** Her own doctor refused to prescribe a lethal medication, as did a second doctor who diagnosed her with depression. The woman turned to an assisted-suicide advocacy group that referred her to a doctor who prescribed a lethal prescription.

In fact, the report states that six people sought lethal prescriptions from two or more doctors. Assisted-suicide proponents claimed this would not happen. They predicted that assisted suicide would occur only after a deep exploration of values between patients and doctors who had long-term relationships.

In addition, information about the people who committed assisted suicide came only from doctors who prescribed lethal prescriptions. **Those closest to the patients—family members and treating physicians—were not interviewed, nor were doctors who refused to prescribe lethal prescriptions.** They could have provided important information about the mental and physical health of these patients.

The investigators did not learn whether the prescribing doctors were affiliated with assisted-suicide advocacy groups, a matter of some importance if we are to know whether decisions are being considered on merits of medicine or ideology. Furthermore, none of the patients was autopsied to determine if he or she was actually terminally ill.

The study also noted that the most frequently stated reason for seeking suicide was a desire for “autonomy” and “personal control,” not the often-cited alleviation of pain or being a burden to the family. In fact pain wasn't a factor in a single one of the 15 suicides. Thus, rather than being a limited procedure performed out of extreme medical urgency, legalized assisted suicide in Oregon has actually expanded the category of conditions for which physician-assisted suicide is viewed as legitimate.

Disability-rights activists point out that allowing assisted suicide based on fear of needing help or performing daily life activities will affect disabled and elderly people far more than terminally ill people. They also note that dependency is a fear primarily for people who are not actually dependent, and that, like other difficulties in life, dependency is a circumstance to which people adjust over time. In fact, nine national disability-rights organizations strongly oppose legalizing assisted suicide.

**The dehumanizing message is that society regards such lives as undignified, not worth living.**

Such lives also include the economically disadvantaged, as Oregon's health plan for the poor pays the full amount for assisted suicide but restricts the amount for long-term treatment. This refusal of care and comfort for the poor sends a clear message that some populations are not valued as highly as others. ○

# Death With The True Story of Oregon's





# out Dignity

Physician-Assisted Suicide Act

# out Dignity

Physician-Assisted Suicide Act

WASN'T A FACTOR IN A SINGLE ONE OF THE 15 SUICIDES.

# Euthanasia and Dis



**“NOT DEAD YET: The Resistance”** sounds a bit ominous, like something straight out of “The X-Files.” But it’s with good reason that the name is a conversation-stopper. This national activist group is at the forefront of the disabled community’s battle against the campaign to legalize euthanasia and assisted suicide. The campaign’s central focus is opposing the infamous Dr. Jack Kevorkian, whose intentions are not quite as honorable as media reports seem to indicate. Kevorkian’s sympathizers present his as a compassionate crusade to help the terminally ill put an end to unbearable pain and suffering. However, as Kevorkian himself reveals in his book, *Prescription Medicine*, legal euthanasia is only the first step in Kevorkian’s plan to create a new class of humans who will exist solely for the sake of medical vivisection and organ harvesting. Many bioethicists have begun to invoke the nearly as chilling “duty to die” rather than decrying Kevorkian’s ideas.

In truth, the majority of Kevorkian’s patients have not been terminally ill. Rather, they have been people who had disabilities and were afraid of the potential consequences of their new limitations: relocation to a nursing home, abandonment by loved ones, or loss of the custody of children. Carol Cleigh, a member of the board of Not Dead Yet, said before Kevorkian’s recent conviction of second-degree murder: “It’s called able-ism. If he [Kevorkian] was a racist or a sexist killer, he’d be in jail.” He is in jail now, after having won precious television publicity on “60 Minutes” to broadcast an assisted suicide. But Diane Coleman, founder and president of Not Dead Yet, says, “Kevorkian is a serial killer of disabled people and should have been jailed long ago.”

Oregon has just legalized assisted suicide and, as if in an act of further spite against persons with disabilities, the state Medicaid agency has cut funding from a number of health services that are vital to the care of people who are disabled and chronically ill.

# abilities

On a more hopeful note, Michigan—Kevorkian's home state—recently voted down assisted suicide in a referendum. Kevorkian supporters defend euthanasia under the slogan “right to die” or “death with dignity.” Despite the passage of the Americans With Disabilities Act, intended to protect the disabled, they are the most overtly threatened by leniency toward assisted suicide.

Until recently the slogan “right to life” has indicated primarily defense of the unborn. Now it needs to be extended to human beings at the other end of life. ○

**“It's called able-ism.”**

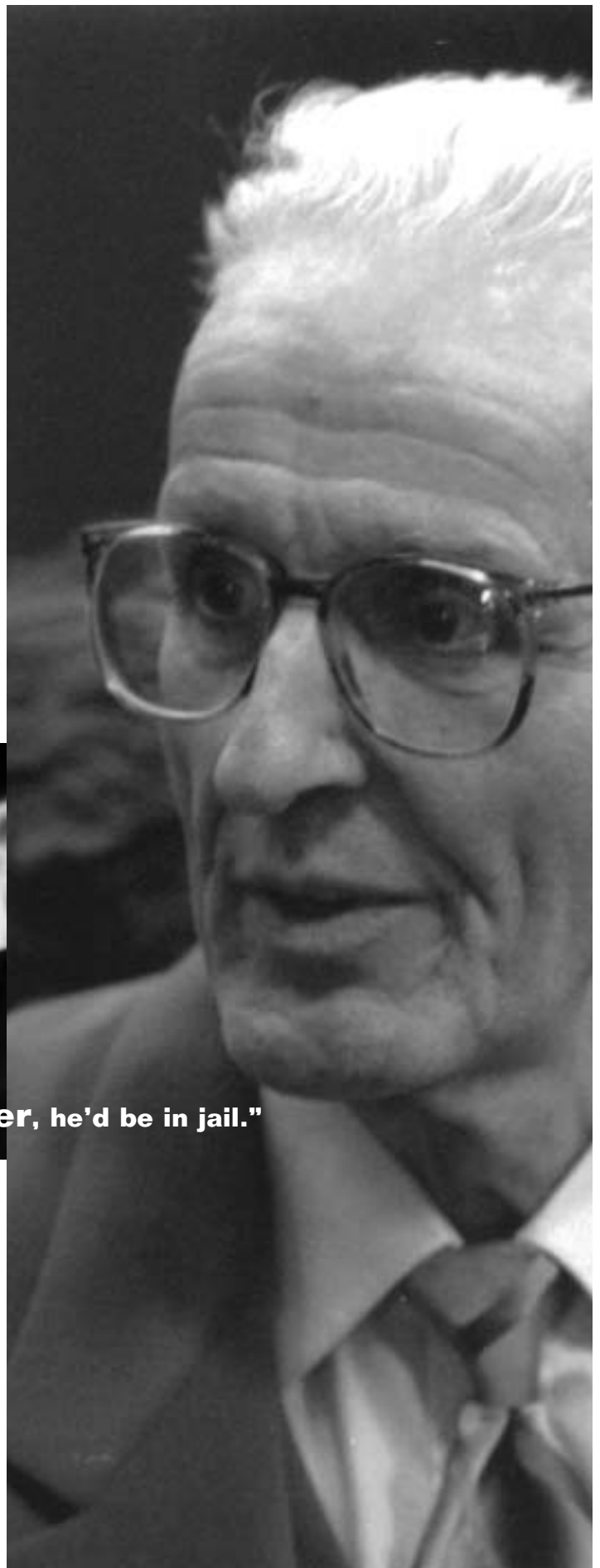


**If [Kevorkian] was a racist or a sexist killer, he'd be in jail.”**

*Not Dead Yet is a national grassroots disability rights organization which opposes the legalization of assisted suicide and euthanasia.*

*For more information, contact:*

*Not Dead Yet, c/o Progress CIL, 7521 Madison St., Forest Park, IL 60130, 708-209-1500 (phone), 708-209-1826 (TTY), [www.notdeadyet.org](http://www.notdeadyet.org)*



# Nazi Euthanasia



**S**INCE ANCIENT TIMES, when sickly children were left outside to die from exposure, euthanasia has been practiced, debated or condemned by various societies. In the late 19th and early 20th centuries the debate over euthanasia took a new turn when it gained popularity among some doctors and lawyers. These advocates proposed that medicine play a role in offering “dying help” to the suffering. Proponents of such an ethic unwittingly laid the philosophical groundwork for the massive euthanasia program that would take place in the late 1930s and early 1940s in Germany.

Although much of the same language and many of the same ideas used by early euthanasia advocates have regained popularity today, contemporary “right to die” activists shun any comparisons to Nazi Germany. Derek Humphry, author of *Final Exit*, maintains that the Nazi era is too “singular and unusual” to merit comparisons. Such statements fail to take into account the decades leading up to Nazi Germany or the emotional arguments and propaganda that were used to justify the euthanasia program.

Works such as Josts’s *Das Recht auf den Tod (The Right to Death)* and Binding and Hoche’s *Die Freigabe der Vernichtung Lebensunwerten Lebens (The Permission to Destroy Life Unworthy of Life)* greatly influenced the German medical profession of the 1920s and 30s. In his book, *The Nazi Doctors*, historian Robert Lifton describes the latter work as “crucial” in creating acceptance among medical professionals for euthanasia and physician-assisted suicide.

Published 13 years before Hitler took power, *The Permission to Destroy Life Unworthy of Life* proposed that “*sterbehilfe*,” the German word for “dying help,” be offered to the “incurably ill” and “lives in a condition of total helplessness, requiring care by another.”

Professor Binding was one of Germany’s leading experts in constitutional law and criminal jurisprudence. Dr. Hoche was a well-respected psychiatrist. The book explicitly stated that “*sterbehilfe*” must be voluntary. But the line between voluntary and involuntary quickly blurred in Hitler’s Germany.

Arguments by early opponents of euthanasia mirror the arguments of euthanasia opponents today. Dr. M. Beer wrote in his 1914 book, *Ein Schoner Tod: Ein Wort zur Euthanasiefrage, (A Beautiful Death: A Word About the Question of Euthanasia)*: “Once respect for the sanctity of human life has been diminished by introducing voluntary mercy-killing for the mentally healthy incurably ill...who is going to ensure that matters stop there?”

The pro-euthanasia movement of that time was not limited to Germany. As Robert Proctor documents in *Racial Hygiene: Medicine Under the Nazis*, support for

legalized euthanasia was widespread in Europe and the United States. A number of British physicians supported Voluntary Euthanasia League, headed by the president of the Royal Society of Surgeons. That same year, an American Nobel Prize winner suggested in his book *Mercy* that the criminally insane should be put to death and economically disposed of. Euthanasia institutions were established in the U.S. using gas.” W.G. Lennox, in a 1913 book at the University, advocated “treatment” for the congenitally mentally ill. Incurable sick who wish to die. A 1911 poll found that 45 percent of respondents favored euthanasia for “the incurable.” In fact, Nazi physicians cited American support for euthanasia in their own arguments for euthanasia in their own country. American support for euthanasia declined after the war.

Nazi propaganda films depicted euthanasia as a loving act. In the Nazi propaganda film *Die Leinwandklage an!* (“The Woman’s Complaint”), a woman who asks her husband who is suffering from a permanent condition to permanently relieve her suffering agrees to give her a lethal injection of morphine while his friend (a doctor) plays tranquil music. In his trial he argues that it was an act of mercy, not murder. He

The situation depicted in the film is almost identical to Dr. J. Robert Proctor’s murder of a woman with a terminal condition. The lethal injection only a few minutes before the character in the film, K

**... the first phase of the Nazi euthanasia program ... actually began with parental requests for the “merciful deaths” of their severely disabled or ill children.**

# Euthanasia Program

**A 1937 Gallup poll found that 45 percent of Americans favored euthanasia for “defective infants.”**

used emotional arguments to sway the jury, and Kevorkian was acquitted. The only difference is that Kevorkian did not play music for his victim.

“I Accuse!” and similar propaganda films greatly influenced German public opinion. It is not surprising, then, that the first phase of the Nazi euthanasia program (titled Operation T4) actually began with parental requests for the “merciful deaths” of their severely disabled or ill children.

The Third Reich soon set up a commission to establish criteria for euthanasia candidates. Those who qualified included children under the age of three suffering from “idiocy and mongolism [Down Syndrome], microcephaly, hydrocephaly, malformations and paralysis.” The child program eventually led to the adult euthanasia program and Hitler’s edict that “Reichsleiter Bouhler and Dr. Brandt are hereby commissioned to allow certain specified doctors to grant a mercy death to patients judged incurably sick, by critical medical examination.”

Operation T4 excluded Jews. Third Reich officials believed that the Jews did not deserve the “benefit” of euthanasia. It was considered too compassionate and humane.

In fact, Nazi doctors justified the euthanasia program on grounds of compassion when defending themselves at Nuremberg.

The words of Dr. Karl Brandt, who headed the program, sound strikingly contemporary:

“Do you think that it was a pleasure for me to receive the order to permit euthanasia?... It is a pity for the incurable, literally. Here I cannot believe like a clergyman or think as a jurist. I am a doctor and I see the law of nature as being the law of reason.”

This same “law of reason” is at work today in the Netherlands, where euthanasia and physician-assisted suicide are both legal and common. The Dutch government’s own research has documented that in more than 1,000 cases a year physicians actively cause or hasten death without the patient’s permission.

In an effort to ensure that the Nazi euthanasia program was carried out in a painless manner, Nazi medical staff at hospitals such as Hadamar originally killed patients by lethal injection. They eventually switched to carbon-monoxide gassing, however, as the program expanded. In the end, more than 75,000 “patients” were killed under Operation T4.

When Operation T4 switched over to gassing, Nazi officials made what they considered a useful discovery—gassing was an efficient form of extermination. After the euthanasia program was officially suspended in 1941 (although lethal injections continued throughout the war), the gassing equipment at Hadamar and other hospitals was dismantled and transported to Treblinka, Auschwitz and other death camps in preparation for the Final Solution. ○



## Hospice Information

For more information about hospice programs, contact the following organizations:

**National Hospice Organization**  
1901 N. Moore St.  
Suite 901  
Arlington, VA 22209-1714  
703-243-5900  
www.nho.org

**Hospice Foundation of America**  
2001 S St., N.W.  
#300  
Washington, DC 20006  
202-638-5419  
www.hospicefoundation.org

**HospiceNet**  
www.hospicenet.org

**National Academy of Hospice Physicians**  
P.O. Box 14288  
Gainesville, FL 32604-2288  
904-377-8900

**National Chronic Pain Outreach Association**  
7979 Old Georgetown Road  
Suite 100  
Bethesda, MD 20814-2429  
301-652-4948

**Molly E. Pannell, Editor**

# OPEN HEARTS AND HELPING H

**A**S MORE AMERICANS find themselves facing terminal illness or caring for family members who are terminally ill, hospice care is drawing increased attention as a positive alternative to aggressive medical intervention in the later stages of terminal disease. Hospice programs have grown by an average of 17 percent over the past five years, according to the National Hospice Association.

When asked to name their greatest fear associated with death, respondents to a 1996 Gallup poll most often cited "being a burden to family and friends." "Pain" was the second most common fear. Hospice's specialized type of care is designed to address both of these fears. The goal of hospice is neither to hasten nor postpone death but to affirm life and recognize dying as a normal process.

"Hospice is like a big family," says Florence Pannell, the author's grandmother and a hospice volunteer in Connecticut. "Whatever is needed—whenever it is needed—hospice is there." By providing essential pain-management services, emotional support and resources for caregivers and families, hospice professionals allow patients to spend their final days with dignity, often in the comfort of their own homes, surrounded by family and friends.

Hospice care involves interdisciplinary teams of professionals. Composed of nurses, physicians, home health aides, social workers, clergy, counselors and other concerned individuals, these teams provide care in the homes of most patients and in nursing homes or assisted-living facilities.

"We care about our patients and we know how to care for our patients," says Pannell. "Hospice team members respect the privacy of our patients while providing quality care." A nurse with more than 50 years of experience, she provides patient care and family support. As part of a hospice team, she works closely with the patient's primary physician, caregiver and family members.



*You matter because you are you.*

*You matter to the last moment of your life,  
and we will do all we can,  
not only to help you die peacefully,  
but also to live until you die.*

— Dame Cicely Saunders, founder of Hospice

# HANDS: HOSPICE CARE

Most hospice programs feature around-the-clock support services—including essential social and emotional support—for caregivers and family members. “Family members can take a break and know that their loved ones are in good hands,” says Pannell. “We have all the resources of the hospice program—medical, spiritual, and social—at our fingertips.”

Hospice programs may provide nutritional counseling, pastoral counseling and legal assistance to family members as well as time off for primary caregivers. Many hospice programs also offer bereavement counseling.

Though payment options differ among hospice programs, most programs are eligible for Medicare and Medicaid funds. Many private insurance companies also cover hospice care. Yet most hospice programs provide services regardless of a patient’s ability to pay. Hospice of Central Pennsylvania, a typical hospice program, is a nonprofit agency that admits all patients on the basis of need and does not discriminate on the basis of age, disease, religion, race or ability to pay.

Thousands of hospice programs daily demonstrate the motto of Hospice of Central Pennsylvania: “A hand to hold, a heart to listen.” In the face of pain, fear and impending loss, hospice offers comfort, peace and dignity to terminally ill patients and those who care for them. ○



## Resources for Caregivers

**Caring for the elderly and terminally ill requires specialized skills. Elder care and caregiver training specialist Kimberly Brooks recommends that all caregivers receive information on the following:**

- **first-aid course**
- **skin care for the bedridden**
- **nutritional needs and fluid intake**
- **administering medicines**
- **maintaining personal hygiene**
- **social interaction—for patient and for caregiver**
- **support from the religious community**
- **the wishes of the patient regarding resuscitation**

**The following books provide information for caregivers:**

- **Share the Care: How to Organize a Group to Care for Someone Who Is Seriously Ill**  
—Cappy Caposella and Sheila Warnock
- **Caregiving**—E. Jane Mall

**The following organizations provide respite services for caregivers:**

- **Meals on Wheels**  
1414 Prince St., Suite 202,  
Alexandria, VA 22314  
703-548-5558
- **Friendly Visitors**  
(a program of the  
American Red Cross)  
Public Inquiry Office  
11th Floor, 1621 N. Kent St.  
Arlington, VA 22209  
703-248-4222



# Herstory

## Worth Repeating

"TO MAKE VOLUNTARY EUTHANASIA LAWFUL would be an irresponsible act ... We should resist any effort to bring in such negative, uninformed, and mischievous legislation." To hear what some euthanasia advocates say about euthanasia opponents, these must be the words of an uncaring extremist—one who is ignorant of the hard, ugly realities of illness, having never been a patient or a caregiver. At worst, this person has untested ideas about the nobility of all suffering and advocates keeping every sick person alive on agonizingly invasive life support machines as long as possible.

Instead these are the words of Cicely Saunders, the mother of the modern hospice movement and the granddaughter of a South African storekeeper widely known for his passionate desire to "care for people rather than to kill them." Biographer Shirley du Boulay remarks that Saunders inherited her grandfather's active nonviolence and used this quality to "revolutionize the medical profession's attitude to dying and death and restore dignity to the terminally ill."

Saunders was born and raised in London. An accomplished student, she pursued a long-held dream of nursing, an ambition that gained urgency when World War II broke out. Du Boulay observes: "She slotted in to nursing and its way of life like a book finding its right place on the shelf." As Saunders progressed through her training, the hard physical labor worsened her congenital back problems. She became too disabled to continue in nursing.

Undaunted, she turned to social work, though she was unsure where best to direct her energies. In 1947, right after she had completed her training, she met a dying man named David Tasma. She was English and Protestant; he was a Polish Jewish refugee from the Warsaw ghetto. Yet they connected immediately, deeply, respectfully. They talked about the needs of dying patients and how these were so often ignored in modern hospitals. They began to imagine new ways to relieve pain, to provide companionship, to help patients achieve a sense of completion and peace about their lives. As du Boulay notes, these talks helped Tasma resolve "unfinished business." "If his illness and death were to plant the seeds of a new, creative possibility, then perhaps his life had not been pointless," du Boulay wrote. And these talks showed Saunders clearly what she

must do with the rest of her life, even if it meant taking on modern culture's powerful tendency to fear and deny death at all costs, not to mention its tendency to shut out women's gifts and insights.

Carrying Tasma's memory with her, Saunders became a physician and went on to found St. Christopher's Hospice, which, since the late 1960s, has inspired people all over the world to humanize the care of the dying. As Saunders explains in *Living With Dying* (Oxford, 1983), hospice care addresses the totality of the patient's suffering. It involves the skilled use of drugs and other interventions to alleviate pain and other troubling physical symptoms. And it creates solutions

for patients' "mental, social and spiritual pain" that honor the unique needs and values of each patient, rather than the beliefs of his or her health-care providers. Hospice gives lie to the wide-spread belief that if a patient's illness is incurable, his or her condition is "hopeless."

Saunders stresses: "From the dying themselves we learn not only to understand something of the ending of life but also a great deal to make us optimistic about all life and about the potential of those ordinary human beings who work their way through it."

Saunders strongly advocates patients' rights to refuse invasive, extraordinary medical interventions, even those that may prolong life. She believes that although medical technology can be used to promote patient well-being, in some situations it can have the opposite effect. She is equally clear in her opposition to killing patients. For decades she has insisted that legalizing euthanasia would "hinder help, pressure the

vulnerable, abrogate our true respect and responsibility to the frail and old, the disabled and the dying." Now in her 80s, Saunders continues to present hospice as a truly life-affirming alternative to our cultural fear of disability and death—and the demand for euthanasia, which arises from that fear. The more our culture takes her rich wisdom to heart, the less perceived need there will be for the "final solution" proffered by euthanasia advocates. ○

*Editor's Note: Ms. Saunders' views on abortion are not known.*

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**Peter Wolfgang**  
**Vice President,**  
**Chapter Development**



## HELP FFL GROW

FEMINISTS FOR LIFE needs your support. We have enjoyed great successes in the last few years. Our College Outreach Program continues to grow, saving and helping lives on campuses throughout the nation. FFL has enjoyed a visibility in the media unlike anything we have previously experienced. And we are on the verge of expanding to the international level, with chapters forming in the United Kingdom and Ireland.

But to keep our winning streak going we need your help. You know how special this organization is. Ours is a unique voice within the pro-life community. Even while attempts to silence our movement increase, our voice continues to be heard—against the culture of death, and on behalf of other nontraditional voices for life.



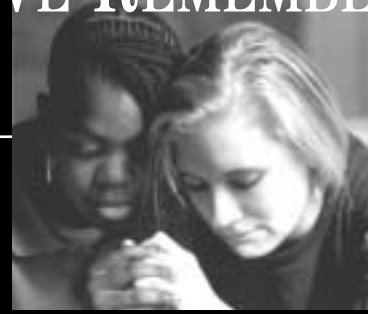
In 1889 Susan B. Anthony wrote, **“Sweeter even than to have had the joy of caring for children of my own has it been to me to help bring about a better state of things for mothers generally, so their unborn little ones could not be willed away from them.”** FFL members—whether mothers, students, fathers or professionals—carry on the legacy of Susan B. Anthony. We need more

members so that our voice may continue to be heard. Everything we do depends on our ability to increase our membership. To help bring FFL's message of hope and empowerment to women you can:

- ask a friend, relative, co-worker or neighbor to join FFL
- distribute FFL brochures
- wear your FFL pin
- put an FFL bumpersticker on your car.
- join or renew your membership—check the address label for your membership status.

And remember that it is because of your hard work that FFL's message is being heard. ○

## WE REMEMBER



### Dawn Ravenell

1971 – 1985

Dawn Ravenell was only 13 years old when she found herself living her worst nightmare. Scared and pregnant, she decided she could not tell her parents, both Pentecostal ministers, about her baby. Dawn was so terrified of their possible reaction to this news that she decided to proceed with an abortion at Eastern Women's Center in New York City on Jan. 24, 1985, without telling anyone.

The procedure was disastrous from the start. Within the first five minutes of the abortion, Dawn began to vomit and choke. Allen Klein, the doctor who commuted from Philadelphia to perform the abortion, inserted a breathing tube into her windpipe and moved her into a recovery room. Left unattended, Dawn once again began to choke and suffered a massive heart attack. By the time a staff member checked on her condition, Dawn had already slipped into a fatal coma. She died at a nearby hospital three weeks later without regaining consciousness.

Dawn's parents were notified about their daughter's pregnancy and tragic abortion when it was too late: She was already comatose. Trying to understand why her daughter did not choose to confide in her, Ruth Ravenell said, "I think that she felt that for me to see her as less than perfect would have been too much." She never got to make her peace with her little girl.

Ruth and her husband successfully sued Klein and Eastern Women's Center over Dawn's death. In December 1990, a Manhattan jury awarded them \$1.2 million in compensatory damages. Since then the Ravenells have become advocates for parental notification and consent laws, testifying before various state legislatures. Klein went on to work at a Pensacola, Fla., abortion clinic, where he was hailed as a hero.

*New York Post*, Dec. 11, 1990; *Associated Press*, Dec. 11, 1990.





# First-Year College Students More Pro-Life Than Ever Before

**...fewer than 51 percent  
[of first-year college students]  
favor keeping abortion legal,  
the lowest level in more than  
two decades.**

**Andrea Milanowski  
Vice President,  
Resource Development**

ONCE AGAIN, college campuses are quiet. Students are temporarily away, yet the forces that work year-round to keep abortion as the first option for college women are fastidiously preparing for the students' return.

The work of abortion advocates is cut out for them in this year, more than any other year before. A survey of American first-year college students conducted by researchers at UCLA shows that fewer than 51 percent favor keeping abortion legal, the lowest level in more than two decades. But as statistics show, pro-choice advocates have a successful track record in reversing the pro-life ideals held by almost half of incoming female students in four years' time.

FFL volunteers and staff are also making preparations. With your support we will be able to reach out to pro-life students as they enter hostile territory. **We will change the landscape of more colleges and universities than ever before from bastions of pro-choice rhetoric to providers of real choices for women.** Together we can challenge schools to accommodate pregnant and parenting students and share the legacy of 200 years of pro-life feminism with this generation who will never meet the one-third of their classmates who have been lost to abortion.

Sponsor the College Outreach Program for your alma mater or begin donating through our electronic funds transfer program—ensuring that our *pro-woman, pro-life* message is heard widely and prominently during this crucial school year.

One out of every five abortions is performed on a college-age woman. No other group of women is more vulnerable. ○

# FFL's College Outreach Program

STUDENTS ACROSS THE COUNTRY are mobilizing to empower women on campus with nonviolent choices—with the help of FFL's College Outreach Program. From California to Pennsylvania students are working with their university administrations, women's groups, and health centers to solve the problems that drive college women to abortion.

■ At Serrin Foster's lecture at the University of California-Berkeley, a student reacted to FFL's powerful new ad supporting children conceived in rape. She shared with the audience that her mother told her that if she had been conceived after *Roe v. Wade* she would not have been born because she was conceived in violence. The audience responded with enthusiastic applause when the student defiantly declared, **"I have a right to be here!"**

■ Pro-life students at the University of Pittsburgh met with Foster after her lecture there to discuss ways to work with pro-choice student groups. Despite their differences, both groups are eager to work together to provide resources for pregnant and parenting students on their campus.

■ *The Battalion*, Texas A&M University's student newspaper, featured a front-page article highlighting Foster's lecture at the university. Student organizers remarked that their group and the university's women's group are "talking about similar, almost identical problems, and we are both trying to provide women with the best solutions for their situation."

These dedicated students at the University of California-Berkeley, the University of Pittsburgh and Texas A&M University—and at many other schools across the nation—deserve accolades for their tireless work on behalf of women and children. FFL members and donors deserve special thanks for giving FFL the resources to help empower these students. ○





### **New Poll Finds Majority of American Women Anti-Abortion**

A new national poll released by the Center for Gender Equality, a women's think-tank headed by former Planned Parenthood executive director Faye Wattleton, found that a majority of American women do not support legalized abortion on demand. Fifty-three percent of female respondents to the poll said abortion should be allowed only in cases of rape, incest, to save a woman's life or not at all, up from 45 percent in 1996.

*The Washington Post, Jan. 29, 1999*

### **Missouri Governor Commutes Death Sentence**

Responding to a personal appeal by Pope John Paul II during the pontiff's visit to St. Louis, the governor of Missouri commuted the death sentence of Darrel Meese, whose execution date had been delayed to keep it from coinciding with the religious leader's visit. Moved by Pope John Paul's personal plea for mercy, Gov. Mel Carnahan commuted the convicted murderer's sentence to life without parole.

*The Washington Post, Jan. 29, 1999*

### **Monkey-Cloning Experiments Fail**

Leaders of the Oregon Regional Primate Research Center in Beaverton announced that they had "utterly failed" to clone a monkey despite 135 attempts. In testimony before an advisory council of the National Institute of Research Resources, the researchers said that their failed efforts show human cloning may not prove as easy as originally thought.

*The Washington Post, Jan. 29, 1999*

### **Retired Supreme Court Justice Harry Blackmun Dies**

Retired Supreme Court Justice Harry A. Blackmun, author of the *Roe v. Wade* decision, died March 4, 1999, at age 90. Upon his retirement from the Court, Blackmun wrote that the *Roe* decision was "a step that had to be taken ... toward the full emancipation of women."

*The Washington Post, March 5, 1999*

### **Domestic Violence Programs Save Men's Lives**

A new study funded by the National Consortium on Violence Research found that the dramatic increase in domestic violence programs and support networks since the

1970s has reduced the number of men killed by partners more than the number of women killed. The study, relying on FBI and local police statistics, found that the number of male deaths caused by "intimate partners" fell to 430 by 1997, compared with 1,357 deaths in 1976. The number of female deaths only fell to 1,174 in 1997 compared to 1,437 in 1976, a decline similar to overall drops in homicide rates during the 1990s.

Researchers for the study say the primary reason for the difference is that domestic violence programs focus on getting women to change their behavior, encouraging them to leave an abusive relationship before they feel the need to use deadly force to protect themselves. Abusive men, however, may be more likely to kill when they feel loss of control over a partner as she tries to leave.

*The Washington Post, March 14, 1999*

### **The World Inside the Womb**

An article published in the February 1999 issue of *Parents Magazine* titled "Your Baby's Secret World" delves into some of the ground-breaking research about a baby's life inside the womb. Among the article's insights: "Some of the most

exciting scientific advances have been the recent discoveries about how much babies actually begin learning while they're still in utero." Unborn infants can recognize the individual tones, patterns, and rhythms of their mother's own voice long before they are born, distinguish human language from other sounds, and "keep the beat" to music. They also respond to their mother's moods, have taste preferences, and play with the umbilical cord like a toy.

*Parents Magazine, February 1999*

### **Study Finds China's Female Suicide Rate Highest in the World**

A recent study released by the World Bank, Harvard, and the World Health Organization reveals that China now has the highest female suicide rate in the world. Fifty-six percent of the world's female suicides—about 500 a day—occur in China, particularly among young women in rural areas. According to the study, China is the only country in the world where more women than men commit suicide each year. The majority of these suicides occur among women under age 45. Since the 1980s, China has enforced a vigorous "one-child policy," which mandates forced

abortions and sterilization of women who conceive more than one child.

*New York Times*, Jan. 24, 1999

### Cell Phone Program Combats Domestic Violence

In an effort to curb rising incidents of domestic violence, Fairfax County, Va., has started a campaign titled "Call to Protect." The campaign involves the distribution of cellular phones, donated by Motorola, to those at high risk for domestic violence. Being stalked, having a protective order, past threats of violence, and a willingness to go through with a prosecution are all solid reasons to receive a phone. Those in charge of the program hope the phones will serve as both an emergency hotline and a security blanket. One Fairfax County woman who has already put her phone to use praises the program, saying, "A cellular phone gives you some sense of security, in that you know that somebody is just a phone call away if you ever need that help." In addition to an increased sense of security, Fairfax County police hope that the cellular phones will enable them to arrive at the scene more quickly before assailants have time to flee. Other counties in the Washington, D.C. area will begin similar programs.

*The Washington Post*, Nov. 17, 1998

### Pregnant Senior Barred from Graduation Ceremonies

Leah Carr of Radcliff, Ky., became pregnant while a senior at Dove Christian Academy. Her life-affirming decision to have her baby resulted in her being barred from her school's June graduation ceremony. In

addition, Leah's title of valedictorian, rightfully earned with a straight-A average, was denied her. Both the school principal and the church pastor declined comment on the situation at the Christian high school. One parent of Leah's classmate, Larry Riggs, expressed concern over the type of message the school is sending by its handling of this situation saying, "She could have hid (sic) it, she could have had an abortion."

*Associated Press*, May 21, 1999

### Study Finds a Gradual Decline in Abortion Providers

A study by the Alan Guttmacher Institute shows that, from the years 1982-1996, the number of abortion providers declined throughout the United States. In 1982, there were 2,908 abortion providers throughout the nation; in 1996 there were 2,042 in operation. The only exception to this trend was the District of Columbia, which reported an increase from 14 to 18 abortion providers over the time span. Reasons cited by the researchers for the trend range from decline in numbers of pregnancies, to women being in older age groups, to changing attitudes about abortion. Despite this decline, AGI estimated that between 1995 and 1996 the number of abortions increased by about 2,000. The 1996 study found that the most abortions occurred in California (238,000), while Nevada had the second-highest abortion rate, after the District of Columbia, with 45 abortions per 1,000 women in the age group 15-44.

*The Washington Post*, Dec. 11, 1998

## GIVE FFL WINGS TO FLY!



**As a growing national organization, FFL is in need of frequent flyer miles. To help FFL expand by donating your frequent flyer miles, contact the FFL national office at 202-737-FFLA.**

### Electronic Transfer Form

*Help FFL Help Women and Children! Your monthly electronic donations provide essential support as FFL works to bring about positive change for women and children. Electronic donors receive quarterly Executive Director reports, detailing FFL's progress. To begin your monthly contributions, simply fill out the electronic transfer form and send it (along with a voided check) to FFL. It's that easy! Donations will be debited on the first business day of each month and will be put to work immediately by FFL. Your participation helps FFL continue the tradition of the early feminists—pro-woman and pro-life!*

I want my bank to transfer monthly donations to Feminists for Life of America. My authorization to charge my account at my bank shall be the same as if I had personally signed a check to FFLA. This authorization shall remain in effect until I notify FFLA, or notify my bank in writing that I wish to end this agreement, and my bank or FFLA has had a reasonable time to act on it. A record of each charge will be included in my regular bank statements and will serve as my receipt.

\$ \_\_\_\_\_ Amount of monthly pledge (\$5 minimum).

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day(\_\_\_\_) \_\_\_\_\_ Eve.(\_\_\_\_) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please enclose a voided check from your account to show the bank's address and your account number.  
Send to: Feminists for Life,  
733 15th Street, N.W., Suite 1100, Washington, D.C. 20005.  
Electronic fund transfers will begin immediately upon receipt.  
*Thank you!*



# LETTERS to the EDITOR

## **FFL On-Line**

I just linked your webpage ([www.feministsforlife.org](http://www.feministsforlife.org)) to a newsgroup yelling and screaming at me over the new S.40 bill introduced by Senator Helms and the subsequent bills that ask for federally funded adoption appropriations.

I wanted them to understand that abortion was the only "choice" the government was currently giving these women. They asked what the cost of the bill might be. Well, I didn't know. But I did know, from reading your page, that there are agencies out there already finding funding and providing it successfully. It was a great opportunity to say, "Call these agencies already providing those services and needing help and ask them."

Thank you for supplying that information! Many saw the alternative not as forcing women to have unwanted children, but providing an alternative for those that don't see any other recourse but abortion.

I was amazed how some staunch pro-choicers took a deeper look and agreed that Senator Helms' new bill had merit. You should be proud to know your page helped in that effort!

While I'll never agree with abortion, I find that opening their eyes to agencies that do more than just picket abortion clinics should be known. The facts your page provides lends irrefutable evidence to the positive good being done.

Thank you!

*J. Matthews  
via e-mail*

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## **Volunteer Journalists, Photographers and Researchers Wanted**

If you would like to be a contributing writer or researcher for *The American Feminist*, please send a writing sample to the editor at FFLA, 733 15th Street, NW, Washington, DC 20005 (202-737-3352). Ability to meet deadlines essential.

Photographers are also needed. Please send samples of your work. Photos will not be returned. Model releases are required to publish work. Releases become the property of Feminists for Life of America.

## **Support FFL's College Outreach Program**

Please accept the enclosed check in support of FFLA's College Outreach Program. Use the money in the most effective manner to reach those young women who are contemplating abortion. I heartily support FFLA's efforts, and I pray for their continued success.

*James R. Park  
Springfield, Virginia*

## **Kudos to The American Feminist**

Like everyone else, life is busy. However, I take the time to read your quality publication *The American Feminist* front-to-back shortly after its arrival. The last issue was especially good. It's nice to see how many life-affirming choices there are to abortion. I passed along that issue to a senior high school librarian for future feminists for life to read.

*Maria C. Wright  
Cannon Falls, Minnesota*



 **EXPRESS YOURSELF**

Some say FFL's recently trademarked logo is reminiscent of a woman reaching out to a child, or a child to her mother. We all agree that it is a joyful interpretation of the classic women's symbol. FFL's stunning new logo pin is sure to be admired. Available in sterling silver or sterling silver plated in 24 carat gold, it measures 2 1/4 by 1 3/4 inches, and comes in a navy-blue gift box. It's a perfect gift for the dedicated volunteer, public servant — or treat yourself! Each is available for \$75.00. (See order form on page 23.) Please specify gold or silver. If you can't decide, get both!

# ORDER FORM

## Membership/Subscription

Indicate number of items:

- \$25 Annual Membership (  new  renewal )  
includes "Pro Woman, Pro Life" bumper sticker and *The American Feminist*
- \$25 Gift Membership (may not be anonymous to the recipient)  
Name of recipient: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_
- \$15 Student Membership ( \_\_\_\_\_ graduation date)
- \$15 Student Gift Membership  
(may not be anonymous to the recipient)  
Name of recipient \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_
- \$35 *The American Feminist* subscription only, non-membership/institutional
- \$30 Annual Membership Outside U.S. (U.S. currency, please)

\$5.00 ea. Back issues of

### The American Feminist

Indicate number of issues:

- Unplanned Pregnancy: You Have Choices*  
Spring 1999
- Remarkable Pro-Life Women*  
Winter 1998-1999
- Victory Over Violence: Rape, Incest and Domestic Violence*  
Fall 1998
- Work vs. Family: The Struggle to Balance Career & Family*  
Summer 1998
- The Bitter Price of Choice: The Aftermath of Abortion*  
Spring 1998
- She'll Ask. Don't Tell: Women's Right to Know*  
Winter 1997-98



**SOLD OUT**

## College Outreach Program Send a Kit to Campus

Indicate number of items:

- \$35 Health Clinic Kit       \$55 Pro-life Feminist History Kit
- \$35 Pro-life Collegiate Kit     \$10 Six camera-ready ads
- \$35 Pro-life Advisor Kit       \$250-500 range for ad placement
- \$35 Campus Counselor Kit
- Pregnancy Decision Questionnaire (*Free* with SASE)

- Please send kit to where the need is greatest
- A college of my choice:

Name of kit recipient \_\_\_\_\_  
 Title \_\_\_\_\_  
 College \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_

**Materials** Indicate number of items:

- \$75 FFL Logo Pin
- sterling silver
- 24K gold plate over sterling
- \$15 *Different Voices* — anthology of pro-life feminist essays
- \$2 "Peace Begins in the Womb" bumper sticker
- \$2 "Question Abortion" bumper sticker
- \$2 "Voices of Our Feminist Foremothers" poster
- \$4.95 *Man's Inhumanity to Woman* — essays by 19th-century feminists
- "You're Not Alone" brochures— 50 for \$5; 100 for \$10; 250 for \$20
- "What Women *Really* Want" brochure — *Free* with a self-addressed stamped envelope
- "You Have Choices" brochure — *Free* with a self-addressed stamped envelope
- \$14.95 *Pro-life Feminism Yesterday and Today* — anthology of pro-life feminist essays
- \$17.50 *Swimming Against the Tide: Feminist Dissent on the Issue of Abortion*



## Donations

- Monthly pledges
- Please send monthly donor envelopes
- Electronic transfer form; see page 21.
- Tax-deductible donation to Feminists for Life

+  15% shipping and handling for materials

\$  TOTAL ENCLOSED

Please print:  Indicate if new address

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City/State/Zip \_\_\_\_\_

Phone (    ) \_\_\_\_\_ day (    ) \_\_\_\_\_ eve

E-mail address \_\_\_\_\_

Please use enclosed envelope or mail to:  
 FFLA, Dept. 0641, Washington, DC 20073

*Thank you!*

OF6/99





*Every day is as precious as the first.*



FEMINISTS FOR LIFE  
OF AMERICA

Because there's a better way.

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