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THE FOR-PROFIT SOCIAL WELFARE POLICY SECTOR AND END-OF-LIFE ISSUES: A TROUBLESOME ETHICAL MIXTURE

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This paper discusses for-profit social welfare and end-of-life issues in the U.S., and concludes that the strong profit motive, plus diminishing budgets, growing demands (such as an increased aged population) and other factors will result in increasing ethical problems vis a vis end-of-life issues. The paper divides as follows: (1) For-profit Social Welfare Policy Sector and Human Service Corporations; (2) Profit Motive Trumps End-of-Life Concerns; (3) Conclusion.

The For-profit Social Welfare Policy Sector and Human Service Corporations

First, the for-profit social welfare policy sector and human service corporations are an increasingly important part of American social welfare policy. Human service corporations are "for-profit firms providing social welfare through the marketplace" (Karger and Stoesz 2006, 2). The for-profit social welfare sector engages in market oriented activities toward the goal of making a profit, much in the same way as the non-social welfare business sector does. The difference is that the "business" of for-profit social welfare is "social welfare," in all its dimensions.

Examples of human service corporations would include Manor Care, Humana, and KinderCare. While all human service corporations are for-profit, not all for-profit human services are sizeable "corporations." They can range in size from large to small (often large). Examples of the voluntary, non-profit social welfare sector would include Catholic Health Initiatives and Ascension Health (two of the larger non-profit Catholic hospitals), Catholic Charities, the St. Vincent de Paul Society, and the Salvation Army. Examples of the government social welfare sector would be programs like Food Stamps, Medicare, Medicaid and Social Security.

The modern neoconservative movement has been active in encouraging the "privatization" of social welfare. Privatization is the "transfer of economic resources from the public to the private sector to meet the social needs of people… (this) is seen in the reliance on private

health, educational, and social institutions and entrepreneurs to provide services" (Barker 2003, 339).

The for-profit sector has achieved increasing prominence because of the rise of the conservative and neoconservative movement, and also because of the increasing disenchantment with governmental and welfare state solutions to social ills (Freeman 1981; Murray 1984). The election of Pope John Paul II to the papacy in 1978 and the election of Ronald Reagan to the U.S. presidency in 1980 were watershed events. The neoconservative view (echoed by President Reagan) was that government was part of the problem. Pope John Paul II, in his historic encyclical, *Centesimus Annus* (1991) stressed the fundamental importance of the human person. The dignity and the rights of the person were trampled underfoot by the Communism and Nazism that Pope John Paul II knew so very well. Pope John Paul II also stressed the importance of the principle of subsidiarity, echoing the statement made by an earlier Pope, Pius XI, who said that one should "not withdraw from individuals and commit to the community what they can accomplish by their own enterprise and industry" (1992, 60).

There are contrasting views of the role of the state in the thinking of Pope John XXIII and in Pope John Paul II. John XXIII, in his now historic encyclical, *Mater et Magistra* (1961), "did a great deal to change our collective attitudes toward state intervention" (Watts 2002, 168). It would be crudely simplistic to say that John XXIII was more of a "liberal" on the role of the state and John Paul II was more of a "conservative." Both indeed argued that the government had a responsibility in social welfare matters. Still, it might be said that John Paul II was, in a sense, more concerned and more critical about the role of the state, based to some extent on his experiences with Communism (and with Nazism).

There is a political and ideological debate that has been taking place about preferring private-oriented social policy or state-oriented social policy (Watts 1995). We can say without very much debate that private sector social welfare solutions have prevailed. The emphasis on the important role of "subsidiarity" has impacted the thinking of Catholic social thought in noticeable ways. The late Rev. John H. Miller (1994, iv) has forcefully stated that the role of the state must always "remain a strictly limited one: limited by the principle of subsidiarity."

The for-profit social welfare sector has risen because of the perceived void that neither government nor the non-profit social welfare sector has been able to fill. The rapid increase of the for-profit social welfare sector is testimony to that, and it has been indeed dizzying. In 2002, the National Association of Social Workers (NASW) conducted a

survey of its members through the NASW 2002 Practice Research Network (PRN) Survey. O'Neill (2003, 3) reported that the private social welfare sector employed more NASW members than the public sector. The rise of the for-profit social welfare sector was particularly pronounced. In 2002, 36% of all NASW members were employed by the for-profit sector (in 1988, only 19.8% were). The private, non-profit sector employed 35% of NASW members. Thus, a sizeable 71% of all NASW members were employed by the private sector, thus surely putting to rest the notion that the social work profession was a government based profession. In a larger framework, the private social welfare sector, and particularly the for-profit social welfare sector, was clearly in a dominant position. As Gilbert said so well with the title of his book (2002), *Transformation of the Welfare State: The Silent Surrender of Public Responsibility*, government had retreated, had surrendered public responsibility.

David Stoesz (2005, 53), one of the most sagacious observers and analysts on the emergence of the for-profit social welfare sector and human service corporations, has observed that:

> Human service corporations have established prominent, if not dominant, positions in several human service markets, including nursing home care, hospital management, health maintenance, child care, home care, corrections, and welfare. In 1981, 34 human service corporations reported annual revenues above $10 million; by 1985, the number of firms had increased to 66; by 2000, the number had risen to 268. Of these, sixteen corporations reported revenues higher than the total annual contributions to all of the United Ways of America!

The for-profit social welfare sector has played such a dynamic and active role in health policies in the U.S. that it is difficult to conceive of a national health plan being developed that does not include an active role for the for-profit sector. The ideological underpinnings for an active role for the for-profit sector can be found in both neoconservative and neoliberal thinking. Neoliberalism "aimed for a more moderate mix of compassion and free market economics…this new Democratic agenda was more optimistic about the potential for corporate contributions to social welfare, and, therefore, more willing to support legislation favorable to the business sector" (Marx 2004, 151). Thus, an array of forces had come together to place the for-profit social welfare sector in an enviable position, a position that appears to be one that will prevail for years to come.

Profit Motive Trumps End-of-Life Concerns

Second, the for-profit motive trumps end of life concerns. Without sufficient profits, business enterprises will not survive. Profits dominate business thinking. Profits determine what corporations succeed in the marketplace, and what corporations will not succeed. Profits are "a prime mover of a capitalistic economy," and "can be said to act as a stimulator of output" (Whitney 1991, 200-201). The power of profits, both for good and for ill, have been frequently spoken about in human history. An Arabic proverb says that one should "live together like brothers and do business like strangers." Ambrose Bierce defined a corporation as "an ingenious device for obtaining individual profit without individual responsibility." Perhaps the most oft-quoted maxim is that of former President Calvin Coolidge, "the business of America is business."

It should be born in mind that human service corporations are indeed profit-oriented businesses, seemingly every bit as much as their non-social welfare counterparts. Beverly Enterprises, Humana and KinderCare all seek profits with seemingly as much verve and drive as does Cargill, McDonald's and Wal-Mart. They collectively often incorporate a "profit maximization" strategy, which can have negative effects. Dominican priest and economist Albino Barrera, O.P. (2001, 169) states that a "profit-maximizing strategy configures economic life to the unbridled pursuit of private interests, the preferential treatment of capital over labor, a macroeconomic strategy of growth-efficiency, unfettered rights, and an understanding of economic life cast exclusively in terms of wealth accumulation."

Profit should not dominate the business enterprise, but making a reasonable and decent profit is good. There should be a balance here. Pope John Paul II (1992:465), in his noted encyclical, *Centesimus Annus*, noted that:

> The church acknowledges the legitimate role of profit as an indication that a business is functioning well. When a firm makes a profit, this means that productive factors have been properly employed and corresponding human needs have been duly satisfied…Profit is a regulator of the life of a business, but it is not the only one; other human and moral factors must also be considered which, in the long term, are at least equally important for the life of a business.

Rev. Robert A. Sirico (2001, 26) states that it is surely not immoral to profit from our wit, resources, and labor. He states further that the only alternative to profit is loss, which can constitute a poor stewardship. With profit, the focus must be on the common good, on the good of the society as a whole (Cadorette 1994, 790). If profit is carried too far, if there is an "all consuming desire for profit," as John Paul II (2002, 380) stated in *Sollicitudo Rei Socialis* ("On the Social Teaching of the Church") then it is clearly wrong. Pius XI so aptly referred in *Quadragesimo Anno* to the "imperialism of money." On the other hand, as reiterated already, profit is a good, if it is ethical, and directed to the common good.

However, people are so often trod upon in the interests of profit. This is certainly in evidence with many human service corporations. Karger and Stoesz (2006, 197-198) list both the advantages and disadvantages of human service corporations. Access to capital, innovativeness and flexibility are a few advantages listed. Disadvantages listed include discriminatory selection of clients, attracting clients away from voluntary agencies, and being perhaps less cost effective compared to other social welfare models. To that let me add a pervasive, overriding "profits over people" orientation. Recipients of human services become "consumers," only numbers that move through the human services system, contributing a profit to the human service corporation. If they are not "profitable" to the human service corporation, then they are discarded, perhaps banished to the public sector (or, in some cases, to the voluntary, non-profit sector). "Profit seeking health and welfare organizations have frequently been charged with 'cherry picking' the most potentially lucrative clients," note Gilbert and Terrell (2005, 127). "Critics of commercial health maintenance organizations (HMOs), for example, charge that they often focus their membership recruitment on the healthy, studiously discouraging enrollments by the sick and disabled." The for-profit mode of the market dominates all areas, including research itself. Biotech corporations, for example, "do not promote research for its own sake or promote healing as an end in itself. Rather, they seek to identify and fill a market niche, then advertise aggressively both to providers and to prospective consumers" (Cahill 2005, 215).

The for-profit orientation is so strong that even life and death concerns often get run over quite easily by human service corporations, eager to make a profit. Wesley J. Smith (2003, 134) notes that Dutch euthanasia policies are carried out in a welfare state health care system that has virtual universal health coverage. This contrasts with the highly privatized, corporate U.S. health care system, with large numbers of

people with no health care coverage. For-profit HMOs in the U.S. are known to punish physicians financially for providing care that the HMO might deem unnecessary, when in fact such care is necessary in the overall treatment plan. This is all taking place in a rapidly changing and financially perilous health care system. Rising costs and declining coverage by employers are occurring at the same time (Moniz and Gorin 2003, 76). Interestingly, Smith (2003, 134) goes on to say that because of all of these factors, "The U.S. experience with the death culture would likely be far *worse* than that in the Netherlands." Whether this would in fact be the case may be open to discussion. But, assuredly, the strong profit motive in American health care is indeed so powerful that everything seems to get throttled in its path. The culture of death environment, now only made more troublesome and far reaching with the advent of cloning, embryonic stem cell research (and other developments) only paves the way still further for profit oriented health care to blaze new paths.

This troublesome mix of corporate, for-profit health care and growing numbers of the aged, growing numbers of people surviving serious accidents, diseases and the like make for a troublesome brew. The late Michael Harrington once said that medical technology is wondrous, yet it somehow comes back to haunt us. Medical technology is keeping people alive longer and longer, creating the possibilities of future social welfare policy challenges that are really unprecedented. Kotlikoff & Burns (2004) have referred to a coming "generational storm." Royal (2005) has referred to caring for a growing aged population as demanding the "wisdom of Solomon." Peter G. Peterson in his various works (2004, 1999, 1989) has warned of major financial and other challenges ahead.

Huge fiscal debts compound the problems we are facing. As of this writing, the national debt is $8.36 trillion, and Congress is preparing to raise the federal debt limit for the fifth time in four years, to nearly $10 trillion. This is almost double the $5.7 trillion gross federal debt of fiscal 2001, when President George W. Bush took office. With all of this, many economists fear that a debt crisis lies ahead ["House Backs Tax Cuts" 2006, 3c]. Indeed, the war costs of two protracted wars, Iraq and Afghanistan, costs the U.S. $10 billion a month, up from $8.2 billion only a year ago. Costs were $48 billion in 2003, $59 billion in 2004, $81 billion in 2005, and an anticipated $94 billion in 2006 (Weisman 2006).

Coopersmith (2006) states that the Iraq war is "consuming over $1.4 billion a week—or $200 million a day…. The war has cost $200 billion already. Economists have estimated the war's ultimate bill will be $1-2 trillion…." The Iraq war "is taking a terrible toll on the Iraqi

people and our military personnel, as well as on the region, our nation, and the world" (United States Conference of Catholic Bishops, 2006 a).

The United States Conference of Catholic Bishops (2006 b), stated that the "very costly conflict in Iraq demands a major commitment of human and financial resources, but Iraq cannot become an excuse for ignoring other pressing needs at home and abroad, especially our moral responsibilities toward the poor in our nation and in developing countries."

Social Security and Medicare face significant challenges in the years ahead. The Dependency Ratio is the number of workers required to pay into the Social Security system to support one retired recipient. It has been increasing significantly, from 5 to 1 in 1960, to 3.4 to 1 in 2001, with projections of 2 to 1 in 2025 (U.S. Committee on Ways and Means 2004). Medicare may even face more formidable challenges than Social Security in the years ahead. The combination of rapidly increasing health care costs, a growing aged population, sophisticated medical technology, prescription drug costs, and other factors have contributed to Medicare challenges. Medicare benefit payments have been a larger percent of Gross Domestic product (GDP) over the years, .74 percent in 1970, with projections of 4.7 percent in 2030, and 9.0 percent in 2075 (Kotlikoff and Burns 2004, 130). The sheer size of Medicare in U.S. health care is enormous. After Social Security, Medicare is the largest social insurance program in the U.S., and the largest public payer of health care (about 1/5 of all health care spending in 2000) (Karger and Stoesz 2006, 304). Both Medicare and Medicaid (also a sizeable program) contribute to for-profit social welfare coffers. Payments for nursing home care accounts are a significant share of the Medicaid budget. The federal government and the states share in covering Medicaid costs, and the burden is growing by the year. Increasing Medicaid costs are one of the biggest challenges facing states today.

There has been in the last several decades "a substantial increase in government financing of social welfare activities" (Gilbert 1983, 7). An example has been the growth of the for-profit nursing home industry, which has paralleled the growth of Medicaid expenditures. One could say also that for-profit hospitals are heavily dependent on Medicare expenditures. The "mixed economy of welfare" (Kamerman 1983) implies that the three major components of social welfare coexist, the governmental, the voluntary, non-profit sector, and the corporate, for–profit sector. Note that the voluntary, non-profit and corporate, for profit sectors are both private sector entities. Both have a dependency on governmental revenues (though not exclusively so). Both can be ethically compromised by governmental laws, governmental financial support, and of course philosophical assumptions and beliefs.

One cardinal example of this, well explicated by John B. Shea, MD (2002, 174-175), is the National Research Act of 1974, resulting in a Congressional order, the Belmont Report, a seminal document in medical ethics. The Belmont Report espoused a set of ethical principles that have permeated medical ethics in all its dimensions (Cassell 2000). "The Belmont ethics" was derived from the philosophical ideas of Kant, Mill and Rawls, and contradicts Catholic ethics. Natural law (and divine law) were ignored. A postmodernist ideology, with its Kantian roots, has permeated medical ethics today. Kant espoused a "critical philosophy (which) undermined the status of metaphysics (and) revolutionized epistemology…" (Rohmann 1999, 217). For Kant, who has been called the father of postmodernism, "one cannot achieve either rational or empirical knowledge of the first principles of metaphysics" (Tannenbaum and Schultz 2004, 234). Kant has had a significant impact on social welfare policies (Kaufman 1999). One can see where this could be leading vis a vis social policies, an ultimate denial of objective truth and the natural law, moving toward the "slippery slope" of euthanasia policies that enshrine human freedom and autonomy (a Kantian ideal), with such dictums as "the right to die" (which seems to parallel the "right to choose" language of the "pro-choice" side of the abortion debate). Ingersoll, Matthews and Davison (2001, 298) state that Kant "so eloquently put it" (that) 'the death of dogma is the beginning of morality.'"

Eyer (1999) states that there are three things that are characteristic of postmodern medicine, the shift from moral to ethical medicine, the shift from community to autonomy, and the shift from healing to relief of suffering. He goes on to say that Hume and Kant introduced the notion of autonomy in modern ethics, so much so that in medicine today, the "autonomy of the patient's self-legislating will is recognized as the methodology of ethics" (Eyer 1999). Perhaps the liberal euthanasia legislation in The Netherlands and some other European countries can be looked at as examples of this kind of thinking.

The profit motive trumps end of life concerns because of the driving force of profit acquisition. Business enterprises "have an obligation to consider the good of persons and not only the increase of profits" (United States Catholic Conference 1994, 584). This combines with an ignoring of the natural law. John Paul II (1993, 31) quotes St. Thomas Aquinas that the participation of the eternal law in the rational creature is called the natural law, and goes on to say that the "Church has often made reference to the Thomistic doctrine of natural law, including it in her own teaching on morality" (1993, 31). Unfortunately, the

prevailing tides of Kantianism, postmodernism and secularism has blinded many Catholics to these great truths. Thus, we have a "perfect storm" besieging medical ethics and health policies, the profit motive of the for-profit social welfare sector (and that of society), a postmodernist philosophical climate, growing aged populations and rapidly increasing health care costs, and other factors all contributing to a "troublesome ethical mixture." This troublesome ethical mixture could become even more troublesome in the future, with inevitable Medicare and Medicaid cuts by government, which in turn reduces the bottom line for for-profit hospitals, which means cuts by these hospitals for perceived extraneous items [this is already happening.]. The U.S. may see euthanasia "come in through the back door."

"If assisted suicide were legalized, managed-care providers would inevitably embrace it as a money-saving technique," notes Pavlat (2006, 18). He goes on to state that a study reported that "doctors who are cost-conscious and practice resource-conserving medicine were six times more likely to write illegal, lethal prescriptions for their terminally ill patients" (2006, 18). He goes on to discuss the experiences of the Oregon physician-assisted suicide program (with its predictable results). Pavlat further asks whether "there is any doubt how profit-minded managed-care providers would react if assisted suicide were legalized throughout the United States? We would see a new stratification of society, where the underinsured would be advised to settle for assisted suicide, while those with better insurance could get the medical assistance they needed" (2006, 18). Such a result is surely unethical and unjust. It would go directly against Church teaching in manifest ways.

Conclusion

Third, the conclusion could perhaps best be summed up by a statement of Paul VI, in *Humanae Vitae* (1968) that "it is not surprising that the Church finds herself a *sign of contradiction*—just as was [Christ,] her Founder."(www.vatican.va/holy_father/paul_vi/encyclicals/documents/). The Church stands for the dignity of the human person all the way through the life cycle, birth to death. This is a counter to the "culture of death" mentality in so much of the world. Indeed, the gospel of life is at the heart of Jesus' message (John Paul II 1995). Protestant columnist Cal Thomas (1995) notes that John Paul II, in his noted encyclical, *Evangelium Vitae*, "condemns in the strongest terms yet abortion and euthanasia….The pope was right and America's contemporary leaders are wrong, no matter what a majority might think

at the moment." The Church stands with the marginalized and oppressed (who may well be the first to die in any euthanasia policy venture), advocating for justice and equality, for equal access to health care. Mackler (2003, 229) notes that in both Catholic and Jewish ethics "all members of the community must be provided with access to needed health care—at least a 'decent minimum' that preserves life and meets other basic needs."

The "aggressively secular, post-Enlightenment welfare state leaves little wiggle room for the individual. Indeed, the individual gets in the way of state objectives…" (Watts 2004, 17). One "state objective" could be that of ridding undesirable, unproductive and expensive to maintain individuals (those being fed intravenously, children with severe cystic fibrosis, etc.) The Church stands up for such persons, countering any attempts at ending the lives of such individuals. The church respects and honors the dignity of the person. In *Centesimus Annus*, John Paul II (1991) entitles Chapter VI "The Person is the Way of the Church," firmly asserting that the Church's social doctrine "focuses especially *on the person* as he is involved in a complex network of relationships within modern societies" (1991, 76).

So, to the question about the for-profit sector, end of life issues, and a consequent "troublesome ethical mixture," how do we make it less troublesome? Assuredly, we must begin with prayer and spiritual renewal. A.G. Sertillanges, O.P. (1987, 29-30) reminds us that St. Thomas Aquinas "tells the passionate seeker after knowledge: '*Orationi vacare non decinas*: never give up praying….' St. Thomas Aquinas discusses many aspects of prayer, one being that it 'makes us friends of God…' (Aquinas, 1939, 160)." This is of special significance because we are involved in end of life decisions that involve humankind in making perhaps unprecedented decisions over life and death issues. We have science and technology at our disposal that involve risks, that can lead us in positive directions, or the opposite (John Paul II 1994, 18).

We must keep the common good in mind at all times. An essential ingredient of the common good is charity, which St. Thomas Aquinas states is the "most powerful of the virtues" (Aquinas 1960, 30). The common good is the "sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily" (from *Gaudium et Spes*)…. The common good "concerns the life of all. It calls for prudence from each, and even more from those who exercise the office of authority…" (United States Catholic Conference 1994, 465). Certainly, important principles like solidarity (something particularly missing in today's world) subsidiarity and, of course, the natural law must be maintained. The natural law is the very bedrock here, and especially vis-à-vis end of life issues.

An active interest in social policy (and, especially, moral issues in social policy) must be encouraged. The U.S. has a Council of Economic Advisors, but not a Council of Social Advisors. Social policies must be more focused on empowerment of the individual through asset accumulation (rather than an emphasis on more "welfare programs," encouraging dependence on government). The principle of subsidiarity would assist us to move away from excessive reliance on the state. The late Fr. John H. Miller (1994, iv), in reiteration, reminded us that there is certainly a place for the state, but it is always "limited by the principle of subsidiarity." Asset based policies are so important because when end of life decisions enter the picture, alongside the motives of the for-profit sector, "money talks." Those with the greatest amount of capital, of assets, have the greatest say over their lives. Sherraden (1991) proposed the creation of Individual Development Accounts (IDAs). The savings rate of Americans is abysmal. This is the route we must go, to avoid the pull toward euthanasia, building up the savings and assets of individuals so that they can resist the brandishments of "economic necessity" vis-à-vis end of life decisions. Early and lifelong saving must be encouraged in every way possible. As pointed out previously, it will be the poor who unfortunately experience the brunt end of liberal, slippery slope euthanasia policies, not the well off.

The United States must come to grips with its budgetary deficits, as Kotlikoff and Burns (2004) point out in their riveting book on the coming generational storm. One helpful way of addressing the problem, they aver, is to adopt "generational accounting," which "directly measures the fiscal burden we are leaving our kids…" (45). This would provide all of us a more realistic picture of the severe budgetary challenges facing all of us (Kotlikoff 1992). These budgetary challenges will have many effects, including pushing us toward liberal euthanasia legislation (such as already exists in several European countries), with the parallel move by for-profit human service corporations to "cut costs," especially focusing on the severely disabled and bedridden, the "expensive" cases.

We must see more equitable access to health care emphasized in U.S. health care policy. Despite the sizeable amounts of money spent on health care in the U.S., the actual state of American health care access is less than satisfactory. The U.S. "remains the only industrialized nation that does not have a system of health care with access to services for all of its citizens, regardless of race, ethnicity, gender, age, employment status, or income" (Moniz and Gorin 2003, 75). There is hope for change at the state level. The state of Massachusetts enacted in 2006 a mandated health insurance plan for all its citizens. There is a parallel

here with required automobile insurance coverage. To forestall health policy coverage problems ahead, one should be required (like the Social Security program) to contribute to the plan at a relatively early age. Citizens should be contributing to a self-care and family care 'pot' from an early age. We could certainly go a long way in restructuring or even replacing large, government-run programs like Medicare, Medicaid and Social Security by doing this (Watts 2002, 2004). Parallel to this, we must "mandate savings" by putting into place policies and programs that would require citizens to save money over the long run, that can benefit them later, that can help reduce dependence on government, as well as dependence on the whims of a for-profit human service corporation with respect to end of life decisions. Long-term savings and capital accumulation translate to greater independence for the citizen. Certainly, a complicated and expensive surgery can pose many significant challenges to health care savings schemes like health savings accounts. The purchase of health care insurance along with health savings accounts would be necessary to make it work. Health insurance would be a kind of back up to the HSA (Watts, 2004:17), a second piece in the model (Hendrix & Kaufman, 2003:85). There are a host of things that could be done to alleviate pressures on the health care system, such as community health centers (more funding is needed here), more physicians, physician assistants, nurse practitioners, and other health personnel, more attention in general given to health prevention measures, and a host of others too numerous to mention here.

Lastly, intensive dialogue with those advocating euthanasia needs to take place. Many of those advocating for the so-called "right to die" movement are secular liberals, who would generally tend to favor abortion, and oppose capital punishment (this seems very contradictory to me). I have found that individuals of this kind would feel strongest about their pro-abortion and anti-capital punishment views, but perhaps more anguished (at times) about their pro euthanasia views. Euthanasia often "strikes home" to them in particular ways.

Pavlat (2006) argues persuasively that dialogue and persuasion is possible on this issue. As a convert from pro-choice agnosticism whose conversion story was printed in *Surprised by Truth 2*, and as a member of Democrats for Life of Maryland, he has a wealth of experience and knowledge to bring to such an undertaking. "Liberals believe in the possibility of correcting injustice," notes Tinder (2004, 217). Democrats of the last several decades have been associated with "greater economic intervention, protection of minorities, a social safety net, including Social Security and Medicare, government regulation, protection of the environment, a less aggressive foreign policy, and the

cause of poor and working-class people" (O'Connor and Sabato 2002, 455). The Democratic Party has been called the "Party of Compassion." So, why not use that as a seminal debating point, "compassion," with respect to end of life issues? A number of Democrats have been persuaded by the fine organization, Democrats for Life (www.democratsforlife.org) that the unborn child, the often forgotten person in the abortion equation, is deserving of a healthy dose of Democratic party "compassion." There is no reason to believe that a directed compassion toward the sick, frail, the terminally ill cannot occur. A group that has already done much good in this respect is the Not Dead Yet organization (www.notdeadyet.org), founded in 1996 by an attorney with significant disabilities (who has used a motorized wheelchair since she was eleven years old), Diane Coleman, JD.

Despite the pressures on the for profit sector to terminate lives in the interests of greater profits, there is hope. I end with excerpts from Pope John Paul II's (1995) great encyclical, *Evangelium Vitae*:

> In such a context suffering, an inescapable burden of human existence but also a factor of possible personal growth, is "censored," rejected as useless, indeed opposed as an evil, always and in every way to be avoided…. In the materialistic perspective described so far, interpersonal relations are seriously impoverished. The first to be harmed are women, children, the sick or suffering, and the elderly. The criterion of personal dignity—which demands respect, generosity and service—is replaced by the criterion of efficiency, functionality and usefulness: others are considered not for what they "are," but for what they "have, do and produce." This is the supremacy of the strong over the weak.

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