Alzheimer's, Medical Ethics, and Choosing Life

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Michael Egnor:

Welcome to Mind Matters News. This is Dr. Michael Egnor. I have as my guest today Dr. Stephen Post, who is an internationally recognized expert on philosophical, scientific, and medical aspects of deeply forgetful people, such as people who have Alzheimer's disease, and he has fascinating insight on the relationship between the mind and the brain, as well as the ethical implications for our understanding of that relationship. So, thank you, Stephen, for joining us.

Stephen Post:

Yeah. That relationship is so important, Mike. Back in my Ohio days, 20 years at Case Med and I traveled all over with the neurologist, Joseph Michael Foley, who was just incomparable. We once drove down to Mount Vernon, Ohio near Kenyon College and there is a geriatric psychiatric institute there. One of the sections of that institute is devoted to people with the dual diagnosis of Down syndrome and probable Alzheimer's disease, because as you know so well, being an esteemed neurologist, that pretty much ubiquitously, people with Down syndrome, by the time they get into their late 40s or early 50s, see a decline in their mentation and it's really kind of development in a reverse. So, they have probable Alzheimer's on top of the Down syndrome.

Joe and I walked into this unit and we saw there were probably 50 people there being cared for so meticulously and so palpably kindly by a whole bunch of Hindu nurses aides. Apparently, these Hindu nurses aides had gone down to Mount Vernon and they had their community there and they were totally devoted to what they were doing. They were not rude, they were not judgmental, they were totally accepting, their tone of voice was warm and kind and uplifting. So, Joe and I were so impressed, we took three or four of them out to a pizza restaurant in a nearby town and we just asked them, "We want to know what motivates you. How are you so committed to caring? Because ethics is so much a matter of caring and respecting the dignity of these individuals. How do you maintain that?"

They said, "Namaste," which all the listeners will know is the Hindu greeting. But it's not just, "Hi, how are you?" It means, "I honor the divine in you." So, what they were saying was that they don't view these individuals as gone, as husks, as empty, as useless eaters, life unworthy of life, to use a Nazi German term. But in fact, they see them as equally valuable because they're still sacred in their being. This is where ethics has to get started with this population because otherwise, every kind of abuse known to the species has been inflicted on individuals who were vulnerable and imperiled because they are deeply forgetful.

Michael Egnor:

It's interesting that that really echoes the ethics of Matthew 25 where Christ says that, "What you have done for the least of these, my brothers, you've done for me."

Stephen Post:

That is a beautiful quote and I quote it in Dignity for Deeply Forgetful People. Joe Foley, who was a very fantastic Christian neurologist, he quoted it too. In fact, we once wrote a chapter in an edited book about the relevance of that verse to the care of this population. So, I appreciate your bringing it up.

Michael Egnor:

Sure. I'm sure we both feel the same way about this. There's very disturbing trends in medical ethics regarding the care for people who have profound cognitive problems. You describe a concept that I actually had never heard of before, but it's absolutely chilling, and it's called preemptive assisted suicide. What is that?

Stephen Post:

Well, I had doubts, Mike, about including that chapter in the book. But the editors at Hopkins, they were fine with it. I use it to mean or to refer to individuals who want to avail themselves of assisted suicide while they still have the capacity to be the agents of their own deaths. One typical case, a friend of mine from Cleveland, her sister was succumbing to more and more severe Alzheimer's, but she was still capacitated and she wanted to preempt the decline. That's the preemptive notion. So, with her husband and her and adult children, she organized her trip to go to Switzerland, and there is an institution there called Dignitas. There's language for you. Now, her sister, who is my friend, was distraught over this because I have an email right here on my bulletin board, it says, "I can't get over it, how I wanted to go and be with her in her final years and let her know that I still loved her, and I'm terribly upset that she went to Dignitas."

Then I responded, "But you can't judge her. Don't judge her. You can still love her, but this is what she chose to do." I don't recommend it. As you'll notice in the book, I give four or five very good reasons against this, philosophical reasons, ethical reasons, and yet in the final analysis, I've known a few people who, even though I recommended that they not do this ... See, partly, my thing about suicide goes right back to Thomas Aquinas and his third argument. The first argument, well, it's hubris. God gives life. God takes life away. That's not too easy to sell in this world. The other argument is that it's against the law of nature. Well, I'm not sure of that. But the third argument is that it has a kind of epidemic quality.

So, when you think about the young people 15 years ago who were jumping off that dormitory roof at NYU, they were following the leader. It was really mimicking that was going on, and that's typically the case. There have been some episodes, by the way, among high school students in Waco, Texas that I've read about quite deeply. So, instead of just one person, a young person killing himself, you had a chain of seven or eight. And Hemingway. Hemingway's father shot himself, Ernest Hemingway shot himself, and his daughter killed herself. You find this runs in families. So, suicide becomes a way of dealing with the difficulties of life and that's why I don't want to leave that as a legacy to my own kids who are growing up now. I just don't want to leave that for them because possibly in a pinch, they will emulate me. So, I stay away from it. I don't recommend it.

But on the other hand, I've known some very, very good people. When I was at the University of Chicago, I had two psychiatrists, both of whom were mentors. One was diagnosed with Alzheimer's. He had a loving family. He spent about eight years in a nursing home in Hyde Park. His family was visiting him often, they were stimulating him, reminding him of who he was with symbols and music, and he did pretty well. There was another psychiatrist who had no family and he just didn't entrust himself to the system. He didn't want to die with a tube in every orifice, natural and unnatural. So, he took 40 seconals and put a plastic bag over his head, and a few days later, it was in the Chicago Sun Times on the front page. That's a tragic thing.

We call these individuals now, I don't know what the language means exactly, but live-alones in the literature, people who have no family, no support, no one to advocate for them, vis-a-vis the possibility of overtreatment. For them, preemptive assisted suicide is somewhat appealing. I wrote an article in one of the major generalist medical journals about a guy who was a street clown in San Francisco. He would do his performances on the library steps there down Market Street somewhere and he was

getting to the point where he was quite deeply forgetful. He had a diagnosis of probable Alzheimer's. So, before he declined too precipitously, he took his small bit of savings, four or $5,000, got himself an airplane ticket, and he went to Dignitas and that's the last anyone ever heard of him. So, I recognize that this is inevitable, that it's going to happen. But my attitude, to quote another scriptural verse, is, "Judge not, lest ye be judged."

I'm not for this. I'm not an advocate by any way, any stretch of the imagination, and yet, I also understand that in our society, given the state it's in, that people are going to avail themselves of these opportunities. They don't have to go to Switzerland. They can go right up to Montreal, and I'm hearing that it's going on in New Jersey, but don't quote me. But it's not legal. It's not legal. And Oregon. So, the assisted suicide laws in the US, you've got to be determined by two independent clinicians to be roughly, give or take, within six months or so of dying. You could have pancreatic cancer or you could have ALS.

If you still have the ability to do this to yourself, you're pushing the final red button that allows the poison to flow into your veins or whatever it might be, then you can do this. But for most people with the progressive dementia of the Alzheimer's type, by the time they're within six months of dying, they have lost their capacity for decisions and actions, purposeful actions a long, long time ago. So, they're basically ruled out. I think this is what's going to happen is you're going to see most of these places in the US in the next several years following alongside Montreal and Quebec and Switzerland and other such places because it'll be viewed as discriminatory to disallow deeply forgetful individuals this "opportunity", quote, unquote.

Michael Egnor:

Right. Right. The kind of a sick twist. I see the assisted suicide question as really, in some sense, three fundamental ethical questions, that is it ethical for an individual to commit suicide with medical assistance, is it ethical for a society to sanction assisted suicide, and is it ethical for the medical profession to play a role in it? I think it's unethical on all counts, but I very much agree with you that we need to show sympathy for people who are in such an existential state that suicide seems to be the appropriate thing to do. There's a great deal of suffering going on there. It's a terrible state to be in.

Stephen Post:

Although, suffering, yes, while they are still insightful into their losses, and I use the word carefully. If there is a kind point in the progression of dementia, say of the Alzheimer's type, it is when people forget that they forget. Then they can have a relatively benign, not universally so, but a relatively benign emotional adjustment. They have lost the temporal glue between past, present, and future. They're living mostly in the pure present, which, by the way, in the popular culture of Zen, is an ideal modality of being. I just had to throw that out. When you spend a lot of time with deeply forgetful people, you can't be too chronologically concerned.

But at any rate, yeah. These are individuals who are not suffering, obviously. You can ask that question. Are they suffering? Well, if they're well cared for, they're not suffering, and well cared for and not insightful into this kind of peeling away of capacities. If people realize that underneath it all, they can be connected with, if we can just listen attentively, notice the subtle purposes in their activities, I think that there's oftentimes a lot more purposefulness in these individuals than we realize. But you have to have a special sensitivity to it and be open-minded about it, which is, again, why I don't like the word dementia because it's just sort of them vs. us, they have declined, they're gone, whereas deep forgetfulness is, look, we all have our moments. I have my moments on the escalator of this building.

Michael Egnor:

The one part of this that bothers me profoundly is the participation of the medical profession in the assisted suicide business. In a way, a doctor carrying out assisted suicide is like a pilot deliberately crashing a plane. It's kind the opposite of your job. I can't fathom a doctor going into work in the morning knowing that he or she will kill a patient that day deliberately. It's the antithesis of medical practice. If you think about it, there's no reason on Earth why, if the society wants to sanction assisted suicide under law, that they have to use medical personnel.

Stephen Post:

Oh, absolutely true.

Michael Egnor:

They could allow judges to write prescriptions if they want.

Stephen Post:

Yeah. Exactly. So, Leon Kass, I was a teaching assistant to a course that he did in the Pritzker School of Medicine in Chicago. He wrote a book called Toward a More Natural Science, which is a classic. In it, there's a chapter called Is There a Medical Ethics Question? Question mark. He's looking for somebody that derives exactly from the logic in Aristotelian terms of the purposes of the healing art. So, for him, the reason why the Hippocratic oath so strongly forbids even counseling someone about suicide, let alone operationalizing it for them, is because the healing art should not ever be confused with the killing art.

Now, he does actually say that if this was ever legalized, you would not want to participate in it as a physician because of your identity and your formation. You wouldn't want to compromise your integrity. But you could have a paraprofessional group. Now, what would you call them? I have no idea. You could call them terminators, you could call them death busters. So, he doesn't use that language, but he suggested it would be better than having doctors be so engaged.

Michael Egnor:

Right. I think the... I believe that the enlistment of the medical profession in this business is a deeply, deeply evil thing, and it bodes horribly for our profession and reflects terribly on doctors and on the medical profession that we would tolerate this, or let alone participate in it.

Stephen Post:

Yeah. The logic you're talking about, it's a contradictory practice. It's as though, think about yourself. You're going into a doctor's office, let's just say your office, and there's a nurse who leans out through the door and calls into the waiting individuals in their chairs and says, "Mr. Davis, the doctor is ready to kill you now." Right? Suddenly, everybody's freaking out. So, the killing art can't be the healing art. You've got to keep those logics separate. Many of the people I've known who have been most seriously opposed to abortion, I know several of these individuals, they were initially taking on most of the responsibility in obstetric departments for elective abortions.

One of my friends, who I knew in Cleveland at the Metro North Hospital, great guy, at a certain point, he just said, "I'm not doing this anymore because I was trained to bring life into the world and that's what I take joy in doing. Whether it's a C-section or a natural birth, that's where it all comes to. The idea that I'm going to be spending the rest of my career doing D&C elective abortions or whatever, it's just not appealing to me." So, he told that to his department chair, and I was involved in these discussions, and

the department chair wisely said, "Well, I think we need to respect your conscience. So, other people in the department can shoulder that responsibility and we're not going to blame you. You have done your job, you've done it as well as you can, and now it's time to move on and we can fill the gap."

But on the other hand, I've known some people who were really excoriated for taking this position. Here at Stonybrook, if you look at the OBGYN department, it's a mix of individuals. Some of them are more comfortable than others, and they have a policy, if you don't want to do abortions, you don't have to do abortions. The medical students who are in the clerkship program, they are specifically instructed that they should not violate their moral conscience. So, if they feel uncomfortable participating or even witnessing abortions, then they don't have to be in the room.

Michael Egnor:

Do you think that that conscience exception is being threatened? My sense is that there is a rather powerful movement afoot to constrain our freedom to respect our consciences in this situation.

Stephen Post:

Well, this medical school we're in, the first founding dean was a close friend of mine for 20 years, Edmund D. Pellegrino. He was also a friend of Joe Foley's, and Ed, as a Roman Catholic, he was opposed to abortion and refused to do it himself. Then the question came to him, well, would you refer a patient to an obstetrician who would in fact perform their requested elective abortion? Ed wrote very controversially at the time. "No, I would not because then I would be complicit," which is an ethical term. "I would be complicit in the act myself." So, that's where Ed came down.

Now, a lot of people who are conscientiously opposed to abortion will actually make referrals. There are some studies on that. It's an area where they're somewhat ambivalent, but they'll make the referrals. But I do think that physician conscience is crucial. How can you practice, how can you have an identity, how can you have integrity if you cannot have your conscience respected in areas that are very, very important to you? I think if we go that route, it's just really the end of medicine. Now, are we moving in that direction? In some areas. In some areas, I think maybe it's gotten so bureaucratic and the expectations as employees to employers is really one of acquiescence sometimes and it doesn't allow people the level of freedom of conscience and activity that was once commonplace.

Michael Egnor:

Well, my understanding is that referral for assisted suicide, at least in Canada, is required for medical licensure, and I could be wrong about that. I don't believe that Canadian physicians are allowed to simply-

Stephen Post:

No. No.

Michael Egnor:

... refuse and not refer.

Stephen Post:

Yeah. I don't think it should be required. A referral should not be required because many people have very strong opinions about this and it violates their integrity. In the military, they have an expression for this. They call it moral injury. When you're taught, you go into the Army or the Navy or the Air ... you're

taught about non-combatant immunity, you're taught about proportionality, balancing harms with the circumstances and so forth, and don't torture. But if you look at the people who were in Iraq, for example, who were involved in some of the torture and the killing, they all had post-traumatic stress disorder and a lot of them are still in the VA medical centers getting help because, again, they were asked to violate their moral substance. That's the thing that I think is so important. So, I don't want to recommend that anybody goes into a profession where they can't be granted the freedom to express and operationalize their most deeply held convictions.

Michael Egnor:

Right. Right. But I do fear it's at risk. I go back a lot, think about why on Earth doctors are expected to play any role in killing any human being, that is euthanasia and assisted suicide and abortion. In all those situations, that is simply killing. If society wants to sanction killing, it should at least do it not with people who are in the medical profession who have an obligation to protect human life. You can ask, well, why is that? Why is it assumed that doctors are the ones who should be doing assisted suicide or the abortions?

Obviously, to some degree, it's because doctors are acquainted with the techniques and the instruments and so on. But there's a deeper issue, I think, and that is that people who are advocating killing want to have a medical rationale. They want to wrap a white coat around the killing and make it seem as though it's an ethical thing. It's healing, it's preventing suffering, all sorts of things. So, there's a deeply evil, misleading lie behind medical killing. So, I advocate very strongly within the medical profession that we just wash our hands of this, that doctors agree never to deliberately kill a patient. It seems such a basic thing, but we're doing it a lot.

Stephen Post:

Yeah. They want the white coat. If you think about this in terms of executions in capital punishment and the like, the AMA itself, the American Medical Association, forbade physician involvement in electrocution or any form of capital punishment, and that's been in place for probably 35 or 40 years. There was a period of time when some doctors were so involved, but it was scandalous for them as moral beings. That's really what I get concerned about is the very being of a physician at the deepest level. How can you ask them to do things that are so much contrary to what they've been taught to do and not to do? That's the moral injury, and moral injury, I think it's one of the reasons, Mike, why we call it burnout. It's not just burnout. People get tired. They quit the profession. There's a lot of attrition, but it's also the moral injury. It's the moral injury of doing things that you're not comfortable with.

Michael Egnor:

Right. Right. So, I guess the best thing we can do about this is to continue to speak out because I think there's a great deal of sympathy for our perspective within the medical profession. But a lot of doctors, a lot of people in the medical profession kind of think of it as something that they're expected to do, that resident training and obstetrics may just think of abortion as some rather unpleasant thing that they're supposed to be doing as part of their training. I really want to emphasize to people in the medical profession that you don't have to kill and that when you're killing, you're not acting in the medical capacity.

Stephen Post:

So, I knew a kid from Queens and he was doing his clerkship in obstetrics. He was Korean American and his major identifying community was a Korean American Evangelical Presbyterian church like you see on

Northern Boulevard. So, that was who he was. But he wasn't sure about his views, wasn't quite sure about his views on the matter of abortion. He certainly didn't fully grasp the right that we give him, and it's very explicitly allowed and encouraged not to be involved. He, anyway, was involved in one of these D&C abortions where there's a tube, a plastic tube, and you can see blood and remnants of small body parts going into a pan. After this was over, he had to leave the room and he went home and he was just unable to breathe for the evening.

He talked to me about this and he said he made a mistake. He did something, he wasn't sure that he was conscientiously opposed to it, but he felt that he probably was. He just wasn't a hundred percent certain. Well, seeing all that and all of its graphic quality made him absolutely convinced that that's not something he wants to do. I don't think he went into OBGYN professionally, but he understood that he was going to exercise his veto power, and more power to him. Now, I have to say that I saw him even three or four weeks later at a small group in a reflection context and he was still speaking about this and trying to process it. He'll never forget what he saw. Now, for other people, this is just routinized. It's just everyday activity. But for him, it was terribly contrary to who he wanted to be.

Michael Egnor:

Well, I was at a meeting of the Accreditation Council for Graduate Medical Education, which is the national entity that accredits training programs for doctors. I was at a meeting about a month ago, and because I'm a program director at neurosurgery, I train the young neurosurgeons here. There was a session on the response to the Dobbs decision that overturned Roe v. Wade on behalf of medical education. It is how do we educate residents, for example, to perform abortions in this new environment? It was in Nashville that the meeting was held.

I was sitting in the audience listening to this realizing that here we're ... and there's a panel of experts of national leading OBGYN people, of attorneys and so on, discussing training residents to do things that in about half the states in the country are now felonies, that this bizarre scenario in which the commission of such acts like abortion is sanctioned by many people in the medical profession when right now in reality means they're felonies in other states. So, I really don't think the doctors should train in these kinds of procedures.

Stephen Post:

That's amazing. Philosophically, Mike, I think ultimately, the abortion issue, if you really look at it almost metaphysically, I'm not talking about social determinants of health and all of that kind of thing, which is important, but it really comes down to Aristotle's distinction between potentiality and actuality. So, if you look at the dominant philosophical view, it makes no sense, it is argued, that someone who is actually a moral agent, who is actually fully, quote, unquote, "a person", that they would have to accommodate an entity that is purely potential and unactualized.

So, as Aristotle pointed out in his view, I don't think he was right, actuality always trumps potentiality. But just on a meditational level, if we think about this, every one of us on the face of this Earth began as the teeniest little speck of potentiality. In the Christian tradition, we don't distinguish between potentiality and actuality. Potentiality is actuality. That's why there are baptisms and baby showers and all kinds of things that go on. We try to create a culture of inclusion. But what we see in these occurrences is a culture of exclusion, sometimes very radical exclusion, and that's ultimately where I think most of the cards are on the table.

Michael Egnor:

Yeah. Yeah. It's a terrible degrading thing. Mother Teresa actually said one time when she visited the United States that one of the greatest evils is that a mother kill her child. If you're not safe in the room, then nobody's going to be safe.

Stephen Post:

It's just a geographical thing. But you can make comments about it. So, to some degree, you're a neurosurgeon, so you know about all the things about brain death and diagnosing it. At what point is a person no longer a person by virtue of brain death? Well, there are arguments about this that go way back to Henry Beecher at Harvard, who, along with Leon Kass, developed the whole brain criteria. But people there, like Robert Veach, a very famous medical ethicist, actually wanted to say, "Well, wait a minute. Even if your brain stem is working and controlling certain physiological mechanisms, if your higher brain is no longer operative, then for all intents and purposes, you're dead." That's called higher brain death. The problem with that is that, as you're well aware, even people who are in the persistent vegetative state, we think of them as dead.

But Joe Fins, who's the leading ethicist at the Cornell Weill New York Hospital and a pretty good friend of mine, he came up with this idea about 15 years ago called the minimally conscious state because he noticed that there were some rare patients who had been diagnosed as PVS and the nurses were saying, "Wait a minute. There's something a little more there than meets the eye," and they were coming out of it. So, instead of confusing the PVS thing, he came up with a new category and that's now widely accepted.

But listen, I know Jewish neurologists, I knew two in Cleveland, and they refused to diagnose brain death because on their grounds conscientiously, even whole brain death, even the situation where the brain stem, the reptile brain, if you will, is no longer functioning, you still have warmth to the touch, with respirator support, you still have breathing going on. So, it may not be integrated and controlled in a central way. But for them, the whole idea of stretching death beyond the point where someone is simply cold to the touch is unacceptable.

Michael Egnor:

Yeah, and I think that's viewpoint that's very much worthy of respect. I've been trained and working in a system where brain death and biological death of the entire brain from the cervicomental junction upward is considered actual death and in which case organs could be harvested, etc. I've declared many people brain-dead in my career, but I see that there are some very serious ethical issues there and I don't consider it a settled ethical.

Stephen Post:

So, I teach in a medical school here and I don't write about abortion. With few exceptions, I think the students view it really as a social-political issue, a social determinants of health kind of thing, and that some people don't have access to elective abortion to the degree that others do. If you look at the recent Supreme Court case where abortion is completely outlawed in say, Kentucky, but not in New York, then it just means the people from Kentucky need to get on a bus and come to New York. But that's very inconvenient for them and disruptive and expensive and usually, these are relatively poor people. So, it gets boiled down to an issue of economic and social equity and equality and so-called justice, and that's what you hear the most about. But nobody really is solidly addressing the deeper metaphysical questions that are most important.

Michael Egnor:

If one talks about social determinants of health, if one is talking only about the sort of difficulty that one encounter if you live in a state that doesn't permit abortion and you want to have an abortion, but there are other social determinants of health that cut the other way. That is that, for example, Black children are aborted at a rate three times, at least three times, that of White children. Poor children are aborted at much higher rates. In many parts of the world, girls are aborted at a much higher rate than boys are. So, there's lots of social determinants in the abortion machinery that are very important, particularly, I think, in the US, the fact that the abortion rate amongst African Americans is much higher, that are never brought up when we talk about social determinants of health.

Stephen Post:

That's exactly right. By the way, just linking this back to Alzheimer's, so some cases of Alzheimer's, as you know, are caused by an autosomal dominant gene. That's the presenilin 1 gene on chromosome 15, I believe, and the more rare presenilin 2, which is on chromosome 1. These are individuals who, if they have that genetic mutation, it will cause them to get Alzheimer's disease pretty carefully defined, usually by about the age of 40. But there are some cases on record of individuals in their 20s, late 20s, with Alzheimer's disease carrying especially the presenilin 2 genotype. So, this is not like the normal late onset Alzheimer's when people are in their 50s, 60s, 70s, 80s, 90s. It's about 2% of people at age 60 and it doubles every five years. So, when you get up into the 80s, you're talking probably about 14 or 15% of the population, given current life expectancies. Of course, it's much worse in Japan where people live well into their late 80s and early 90s on average.

So, I was on a national public radio program with a woman from Chicago, this is probably 20 years ago, and she had decided to have a selective abortion because her fetus, based on amniocentesis, carried the presenilin 1 gene. She as a teenager had cared for her father who had the early ... This is the rare early onset form of Alzheimer's. It only contributes about 2% of total cases, and it's very irrelevant to the general masses of people. But these are special circumstances. So, she had cared for her father while she was a teenager, a young teenager, and it'd been very disruptive, of course, for her family. She never herself got genetically tested. You can't get genetically tested for any of the susceptibility genes like the apolipoprotein E4, but you can get genetically tested at a testing center for the autosomal dominant stuff, which it was what was affecting her family, obviously.

So, she did not get tested herself. No, I'm sorry. Yeah. She actually did get tested herself when she was pregnant and she found that she carried the dominant gene, and that meant that her fetus carried it as well. So, she wanted a selective abortion. A lot of people reacted very negatively to her saying, "How much do you want to control the life and lifespan of your child? Your child anyway could have 35 or 40 years of good life, could do wonderfully creative things, and maybe they'll come up with a real solution to the Alzheimer's problem during that period of time." But she still, she just didn't want to have anything to do with it.

So, I said, "I don't condone this. I think how much should we be controlling the lives and the lifespans of our children? Well, maybe you can talk about certain conditions, Tay-Sachs and so forth, but this is really stretching it." But she wanted to have it anyway, so I said, "Well, look, I'm not going to condemn you. Judge not, lest ye be judged," and I think she went ahead eventually and had her selective abortion. But that raises the question of just how much are we moving toward perfectibility as a notion of human fulfillment? Because if you think about it, any elective abortion or selective abortion is going to be based on the age of onset of the illness, and it could be immediate, it could be 10 years down the road, it could be 80 years down the road, and also the severity. Is it something that's very severe or not so severe?

So, I don't have decisions in my pocket for individuals, but I think they have to consider these things much more carefully maybe than we are because these days, selective abortion for a ... When I was at

the University of Chicago, we had a case where a mother who had not been able to get pregnant for many, many years, she finally got pregnant and then they showed on ultrasound that the fetus, I think in its seventh or eighth month, had a clear cleft palate, and this mother had a particular thing about cleft palates. Even though they're surgically correctable now in remarkably effective fashion, she still wanted her selective abortion. So, she got her selective abortion and she never got pregnant again.

Michael Egnor:

Well, the tragic irony there is that one could consider the willingness to kill an innocent human being because of a medical problem like that as kind of a negative aspect of a human being's personality. But these same human beings who are killing other human beings because of a cleft palate, I think it's a horrendously ... It's a sad state that our society is in and sad state that the medical profession participates in.

Stephen Post:

Mm-hmm. Yeah.

Michael Egnor:

Well, thank you so much, Steve. It has been a privilege and a pleasure to talk with you and maybe we can do a lot more of this because I think these are fascinating topics.

Stephen Post:

Sure. If anybody wants to get ahold of me, my website is stephen-, with a P-H, -gpost, stephengpost.com.

Michael Egnor:

Your new book, Stephen, what's...

Stephen Post:

It's Dignity for Deeply Forgetful People: How Caregivers Can Meet the Challenges of Alzheimer's Disease, and it's out with Johns Hopkins University Press and it's having a pretty good impact.

Michael Egnor:

Well, I'm getting that book and I look forward to reading it very, very much and I just want to thank you for joining us.

Announcer:

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