By helping more than 40 depressed sick people to kill themselves, Dr. Jack Kevorkian has helped give life to the controversy over assisted suicide—and won scattered acclaim as a humanitarian crusader. McHugh, director of the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins School of Medicine, says Michigan’s “Dr. Death” is outrageously, even insanely, mistreating those who put themselves in his care.

“Most suicidally depressed patients are not rational individuals who have weighed the balance sheet of their lives and discovered more red than black ink,” McHugh writes. “They are victims of altered attitudes about themselves and their situation, which cause powerful feelings of hopelessness to abound.”

Their depression is treatable—and it should be treated. Modern medicine no longer regards even terminal illnesses as “signposts to the grave,” he notes, but views diseases rather as “processes in life for which the body has ways of compensating and resisting, even if only temporarily.”

Depression among the seriously ill comes in two forms, McHugh says. Patients with certain illnesses—including Parkinson’s disease, multiple sclerosis, Alzheimer’s disease, AIDS dementia, and Huntington’s disease—are often afflicted by depression as a symptom of their ailments. “They are overcome with a sense of hopelessness and despair, often with the delusional belief that they are in some way useless, burdensome, or even corrupt perpetrators of evil . . . ,” he writes. “These patients lose their capacity to concentrate and reason, they have a pervasive and unremitting feeling of gloom, and a constant, even eager willingness to accept death.”

Though that may seem a reasonable assessment of the patients’ situation to family members and physicians, it is actually part of the illness, as much a symptom of it as fevers, pain, or loss of energy. Modern antidepressant drugs, McHugh says, are “usually effective at . . . restoring the patient’s emotional equilibrium.”

Of course, some seriously ill patients are suicidally depressed for other, “perfectly understandable reasons, given thegrueling circumstances of their progressive and intractable disease.” But their demoralization—unlike symptomatic depression—tends to wax and wane, to come in waves, and to be worse at certain times, such as during the night. “All patients afflicted with disease—curable or incurable—are susceptible to bleak assumptions about their future and their value,” he says. “These susceptibilities can be magnified or diminished by the behavior of their physicians.” In short, demoralization, too, is treatable.

Most pain-ridden patients suffering from terminal or progressive diseases do not in fact go in search of death, McHugh points out.
Those who do are not the norm; they are people who need the help and protection of their physicians. The death-dealing Dr. Kevorkian instead “trades upon the vulnera-

Chilling Out Los Angeles


Los Angeles could be a cool place. But right now, it isn’t. On a typical summer day, the temperature in central L.A. is a full five degrees F. higher than in the surrounding suburbs and rural areas. Many other big cities are also overheated. Is this, as many assume, due mainly to heat generated by cars, office buildings, and factories in the city? Guess again, say Rosenfeld, Romm, and Akbari, who are with the U.S. Department of Energy, and Lloyd, who works at the Desert Research Institute in Reno, Nevada. That heat accounts for only one percent of the temperature difference. The chief culprit, they say, is dark surfaces, such as roofs and asphalt pavements, which absorb heat that lighter surfaces would reflect away.

“With white roofs, concrete-colored pave-

Stop Talking Race


Most anthropologists agree that race is an unscientific concept, that distinct biological races simply do not exist. Yet even scientists themselves fall into the race trap, observes Goodman, an anthropologist at Hampshire College, in Amherst, Massachusetts.

Anthropologists and medical and health professionals use race “as a shorthand to describe human biological variations,” he says, even though those variations “blur from one race into the next, and are greater within so-called races rather than among them.” Whether racial shorthand is employed in police work, medical studies, or public health situations, Goodman argues, the fact remains that “race science is bad science” and can be misleading, even dangerous.

Take forensic anthropologists, for example. They maintain that while race may be “socially constructed,” the people in one racial category still tend to look enough alike to make “race” useful in police forensics. To back this up, Goodman says, the anthropologists often cite a study done in the early 1960s suggesting that it is possible to correctly identify the “race” of a skull between 85 and 90 percent of the time. But, he writes, in three of four efforts to replicate the study, “the formula proved less accurate than a random assignment of races to skulls—not even good enough for government work.”

Race thinking, Goodman contends, sometimes leads criminal investigators needlessly astray. That happened in the aftermath of the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City. A forensic anthropologist concluded that a leg found in the rubble that did not match any of the recovered bodies probably came from a “darkly complected Caucasoid” male. But the leg eventually turned out to belong to a woman who was, according to one forensics expert, “obviously black.”

The use of race as shorthand in medical