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WADE AND BOLTON: MEDICAL CRITIQUE

ANDRE HELLEGERS, M.D.*

I don't know where to start except with the thought of life.

It's as good a point to start as any.

What I thought I ought to do is review for you some of the phenomena that have been occurring in the past couple of years and some of the phenomena that have been occurring recently just so that you are up to date on what is happening in various Federal Government Committees, NIH and areas such as this and where one can foresee a number of problems. I want to remind you very briefly of a few key fetal physiology facts that are commonly brought up as questions in anything to do with abortion, or right to life amendments.

I want to remind you first of all, that fertilization of the human egg does not occur in the womb, but in the tube. Do people know what I mean by the womb and the tube? The womb looks like my body, tubes are kind of like two extended arms, and if I had two footballs in my hands you'd have two ovaries and you would get some idea of how things work. So all right, fertilization then occurs in the inside of the tube and it then takes seven days for that fertilized egg to come down the tube and implant in the womb. I want to remind you that it is only when that fertilized egg implants into that womb that we can tell that the woman is pregnant because it is only at that point that this fetus begins to produce a substance, a hormone, which is the hormone that we test for in pregnancy tests. So what we do is take a blood sample from the mother and by testing for the hormones in it we can tell that there is a fetus around because he's sending us these signals through his hormones. And what is of some importance is that it is nine days after fertilization that we can first tell whether a pregnancy is there. That is by modern techniques not yet universally available, but which are accurate, called radioimmuno assay, for those who want it spelled out. What this means, in essence then, is that we can test for the presence of a fetus before a mother has ever missed a menstrual period. So within the month itself in which the pregnancy occurs and before she ever misses a period we can tell whether a fetus is there, if we use high grade laboratories. If not, then pregnancy tests will become positive only after the woman has missed a period and that would be something like one week to two weeks after she has missed a period. It's

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important I think that you know that from the ninth day onward it is theoretically possible to test for pregnancy and in the first nine days it is not possible to test for pregnancy. This simply means that it is up to that time impossible to prove that a woman is pregnant.

I want to give you a few other key points in the course of pregnancy that are important. Important, somewhat, I think is the fact that in the third week of pregnancy, a spontaneous fetal heart starts. Why do I consider that important? Because by analogy of beginnings and ends of life it is at least unlikely that we would say at the end of life that we would pronounce somebody dead rather than alive if they had a spontaneous heart beat. We have had difficulties, as you know, in the laws of transplantation to determine whether there is a spontaneous heart beat. This is the result of the fact that when you have somebody on a machine and maintain their respiration, the question becomes whether such a heart beat should be considered spontaneous. And consequently it is in those cases that people have tested for brain waves, the brain wave absence telling you this heart beat will never recur spontaneously. It is actually an artifact, if you like, from the fact that you are being put on the respirator that is maintaining your respiration. How does this apply to the fetus? The fetus has a spontaneous heart beat from the third week. But it is difficult to know what his respiration status is because he gets his oxygen via the placenta from the mother. And now the question is, do you want to consider the placenta as an artificial respirator or not. And nobody has ever given a good definition of respiration. Namely, whether that is something that requires movement of the chest and expansion of the lung, yea or nay, or whether you can talk about respiration as the intake of oxygen. In that case, the placenta would be, in a sense, a lung.

The next stage I want to bring up for a moment is an eight week stage, the eighth week stage being of some importance because the electroencephalogram or the brain waves begin at that point. Of some importance, because there have been legal cases, although I know nothing about the law, but I think there have been legal cases in which it has been ruled that if there is no spontaneous respiration—if a patient is on a respirator, has a spontaneous heartbeat, and is being maintained with that heartbeat through the respirator, but has no EEG, that is to say, the EEG is flat then the heart may be removed for transplant purposes. In other words, that definition of death would entail the absence of an electroencephalogram with the absence of spontaneous heartbeat, with the added proviso that the heart may beat only as a result of the lung respirator and is then not considered spontaneous. It has led some people to say that if there are only two conditions in which you can be, namely alive or dead, and if the courts rule that the presence of an electroencephalogram at the end of life denotes life, then one ought to at least say that from the eighth week in fetal life there is life by the same criteria as are presently used at the end of life.

An important point that you ought to be aware of is the thirteenth week of pregnancy. That is only technically important to an obstetrician,

if one would call him that, who would be interested in doing an abortion. Prior to the thirteenth week methodology can be used which is "relatively safe." After the thirteenth week the danger in abortion markedly changes with two procedures then being used. Either a small cesarean section to take the fetus out, which is called a hysterotomy, or else the injection of a salt solution into the uterus which causes the woman in time to go into labor and expel a dead fetus.

The next critical point in medical language is the twentieth week of pregnancy, at which point the obstetrical profession no longer talks about abortions, whether spontaneous, induced or whatever. After the twentieth week we talk about premature deliveries. It is at about the twentieth week that the fetus will weigh someplace between 400 and 500 grams. And as you know the smallest infant that ever survived weighed 393 grams. Between the twentieth and twenty-eighth weeks the chances of survival are 10%. Obviously, the longer one goes the greater the chance of survival.

The court has held in general that in the first to the thirteenth week, by virtue of the fact that abortion at that point is a safer procedure than to go through with childbirth, States may not interfere with the performance of an abortion as far as I read it. The right to privacy at that point operates. A word about the misuse of statistics. There are two classical examples of misuse of statistics nowadays. One is the statement, "the pill is safer than childbirth." I happen to think the pill is a very good contraceptive, but for reasons other than that it is safer than childbirth. For the following reason: Anybody who wants to go on the pill comes into the doctor's office and gets a physical workup. If they have a bad heart, bad lungs, bad liver, bad kidney, tumors or whatever you like, you are not allowed to go on the pill. Right. So all the "sickies" are off the pill, all the "wellies" are on the pill and then the data comes out that the "wellies" do better than the "sickies." Well, this is of course a terrible misuse of statistics, but it's the kind of thing that gets bandied around. The same thing is true for saying that an abortion is safer than childbirth, on several grounds. First of all to have a childbirth you must live for nine months, because that is as long as it takes. To have an abortion, you need only live for two months or three months and it stands to reason if you live for nine months you have a larger risk of dying than if you live for two months. I think 90 year olds know that indeed that's the way it is. So, that's problem number one. The second problem is that should one die prior to an abortion being performed, you are then counted not as an abortion mortality but as a birth and pregnancy mortality. So that fundamentally, what one ought to do when one makes such a statement is that one should compare the procedure of abortion with the procedure of childbirth. Unfortunately what happens is if you die from anything else in pregnancy you are assigned to the death category of the childbirth and not of the abortion. The third problem is that the samples are not comparable, because any woman who is severely ill with heart disease or with whatever else you want, who wants to get pregnant and who refuses to get an abortion is automatically assigned to the child-

birth death statistics. So once again the childbirth death statistics at the present time deal with a group that contains many "sickies" and "sickies" who decided "By God I am going to have a child." So what is happening here is that comparative statements are made in which the death of the procedure of abortion is compared with the whole of the death that has to do with maternity regardless of whether people are well or not and it is just simply lousy use of statistics. But I don't think law schools probably teach epidemiology, that's probably one of the problems. Now as I understand it the courts presently state that beyond the thirteenth week, by virtue of the fact that at that time it is agreed that the abortion procedure carries a higher risk than the childbirth procedure, the states are entitled to regulate where these abortions will be performed. And at the twenty-seventh, or thereabouts week, and I don't know where they drew it from, the states can evince an interest in the fetus as such. What is to me the most interesting fact about the whole decision is that, if I understand it correctly, it is said that the states may not forbid an abortion if that abortion is necessary to preserve the life or the health of the mother and that it outright buys the World Health Organization's definition of health. The WHO definition says that health is a state not just of the absence of disease but involving the presence of a sense of well being. So that if one doesn't have a sense of well being, one is ill by WHO standards. It mentions such things as stressful circumstances and all these kinds of things. I would simply say that as a result of that, it is reasonable to say that any woman walking into a doctor's office gives you ipso facto evidence that she is ill. If the situation is stressful enough that she walks into an obstetrician's office you know she meets the criteria for abortion right there. I am reminded of the statements that were made after rhythm became an acceptable method of family planning "for serious reasons," as I think it was said in the Vatican, the question then became how could the confessor know whether there were "serious reasons." I think the standard statement was made "You may assume that there are serious reasons if they practice it, because nobody would do it for the heck of it." It has that kind of inherent logic in it. I think that this is the logic which many, or most, obstetricians would indeed use in deciding in an abortion or request as to whether there was or was not "sufficient reason." They would in essence say: well, there must be a proven need or they wouldn't be here.

All right, to go back for a moment to the matter of the start of life. To say what has been said again and again that we know very well when life starts and it is at conception. It becomes clearer by the day as we begin to get into the business of in vitro fertilization—fertilization in test tubes. One can say it until one is blue in the face that if you start with a test tube full of sperm and a test tube full of ova you can wait till Hell freezes over—nothing is going to happen until you start mixing your two test tubes worth, in which case you're in business. So from the laboratory point of view the start of life is eminently clear. As a consequence, I and many others have resented the fact that this question of when human life starts

has been totally falsified. The issue really is when human value or human dignity or soul, or whatever you call it, starts. The issue is not when biological life starts because we know it. We know it's human. Just because there's nothing great about being human, it's just a category you are assigned to that differentiates you from cockroaches, elephants, cats, rats, monkeys and so forth. It's purely a biological term or category but unfortunately again the word human is being confused with such things as "value", "dignity", "soul" or "worthiness of protection" or with "person" or whatever else you want to call it. So I don't think there really is a biological debate as to when life starts, but there is a value debate as to when life starts. And, you know, I repeatedly said I don't want to prostitute the medical language to solve a problem that is not of biological origin. There are some new movements on foot. It's my understanding that Dr. Watson, Nobel prize winner of Watson and Crick, has come out with a statement that human life doesn't start until the third day after birth. The third he wants, I think, for quality testing. I understand Crick has just come out with a statement that people beyond the age of 80 should not be called human. And the only optimistic note there is, is that I think Justice Douglas is beginning to push 80, isn't he? Getting close to that at any rate. But these statements are nonsensical from the biological point of view and I hope that nobody will confuse the biological with the broader issue of whom shall we protect, attach value to and so forth.

Let me talk for a moment about consequences of the Supreme Court decisions. I foresee two, one of which is already upon us, and I want to spend some time on it. First is the problems of hiring and firing in medical schools, in hospitals and so forth. In which, if I understand it correctly, it's fairly clear that one may not be fired for not performing an abortion. It is less clear to me whether one may not be hired. And at any rate I think it's well to know what the British experience has been. What one does is to not hire physicians who won't do abortions rather than firing those who are already in the hospital and who don't want to do them. So I think it will be the hiring practices that are worth watching and medical schools are beginning to ask such questions. By the same token I think there is a sticky point which is that one ought to be very careful in Catholic hospitals that one doesn't get into the bind of asking the same question, and then being told that we do it for opposite reasons.

The second and very obvious consequence that bursts open immediately is what are going to be the consequences for fetal physiology research? Let me quickly go over that. In what way would we use fetuses for research? There has been a British committee headed by Sir John Peel that had to deal with precisely this issue. And it's foreseen that the fetus is now being used for research in four different ways. One, the fetus inside the uterus of the mother can be used for developmental research by administering to the mother a number of drugs and seeing what effect this will have on the fetus. So that is drug testing in utero, if you like. The British, incidentally, have objected to that on the grounds that the mother might want, at the

last moment, to change her mind occasionally, and since you then have already given the drug the damage has been done. The second type of research involves the use of tissues from dead fetuses after abortion. I said from dead fetuses. And nowhere have I heard great opposition to that. The third one involves the use of tissues of the live fetus, removed from the live fetus, for transplantation into live newborns. The tissue that is most likely to be used, and has been used, is the thymus gland of the fetus which provides immunity to children who are terribly prone to die by infection. So that what is beginning to happen is that the thymus gland is excised from fetuses produced from abortions while they are still alive and then transplanted into newborn children to give them immunity to infections. The last kind of experimentation is experimentation on the fetus alive and removed by hysterotomy. So these would be fetuses procured between the thirteenth and twenty-sixth week of pregnancy. It is said they cannot survive, and these fetuses are then used, by and large, to determine what the action of certain agents is within the bodies of developing children. Some interesting questions are arising within NIH on the count. I'm sure you've read the newspaper reports that said that a number of high school kids marched to NIH to protest the use of live fetuses. When the story first broke in the Washington Post, in a moment of panic, some high officials at NIH stated that NIH did not intend to finance any such research. Now I would simply tell you that you can forget that statement. Just simply because there will be a lot of pressure from fetal physiologists or people from the scientific community to use the fetus and the issue is up for grabs. At the present time the issue comes in the context of a broader one, which I think you ought to be aware of as lawyers.

The whole of NIH and the scientific community is rethinking the matter of consent for experimentation in medicine. I suppose it goes along with consumerism, truth-in-packaging, truth in lending, and so forth, and this is just one symptom of the whole movement. Informed consent in adults, people haven't had much difficulty with at NIH technically, or any place else. The issue obviously concerns children, the retarded, the incompetent in some form or another, and who shall give consent on their behalf. In general, the approach has been that the next of kin, or parent, gives the consent for the use of his or her child for research studies. The interesting issue in this approach is that it is assumed the mother and/or father are most likely to have the interest of that child at heart. The tricky issue in the fetus is, of course, that the parents have given very clear indications that they do not have the interest of the fetus at heart or they would not have aborted it. So now, the tricky issue comes from whom would one then get consent? And certainly, the parents are no longer an adequate group since they have just shown that they don't fall within the category of adequate protectors of the fetus, if you like. I wonder, and sort of look at Bob Byrn, whether someday somebody is going to constitute himself a guardian ad litem for an already aborted fetus, alive, to protect him from experimentation because I think it would be a very interesting case. It

would be interesting because you could no longer postulate that that fetus was infringing against a maternal interest. It is now outside the mother, so it strikes me that it is not invading its privacy, it's not hurting its life, it's not hurting its health, and it seems to me that a court could not hide behind conflict resolution. It would now have to call the shot directly. Yes, it is a live human being, or no, it is not a live human being. And I could foresee that a whole new story might arise. It's interesting that a group of Christian ethicists, 90% Protestant I think, have signed a statement that is being sent to NIH, saying that there are serious ethical problems involved in the use of the live fetus that ought to be widely discussed.

Now, increasingly, in recent years, NIH has followed a second principle and has asked itself the question: what can parents ethically give consent for in their children? And the tendency has been to say that if the child, itself, did not stand to benefit from that experiment as much as it stood to lose, the consent of the parent will not be considered to be sufficient. So increasingly there has been a suggestion that says there has to be an ombudsman introduced someplace in the whole system of consent giving. I think NIH will go for the ombudsman principle. It's interesting because this is sometimes called the beneficial research principle. There has been an increasing tendency to prohibit what is called non-beneficial research. That is to say, research from which one cannot postulate that that child itself might gain as much benefit as loss. From that point of view, there is a very interesting editorial in the mid-April New England Journal of Medicine, a very prestigious journal. Written by its editor, Dr. Ingelfinger of Boston, it asks for a reversal of this rule, stating in essence that society has the right to the information and that panels of many talents will be able to decide whether the child will be used experimentally or not. This is the first indication that I have that a serious journal is now saying that one may proceed with experimentation on children even without parental consent. That a panel can give consent rather than somebody who stands in *loco parentis* of the person. If that were to be what is upon us, then I think it would be a very marked change. It is interesting in Watergate days, that one might actually "bug" somebody without consent. Now I stand surprised how many people are terribly upset about Watergate, and "bugging" without consent, who would be perfectly willing to "bug" human fluid or body, in the absence of consent. But it is an issue which is upon us, and I think a very serious one.

Now a short word about things like constitutional amendments and posting notices in hospitals. Anything that deals with any human right amendment I hope will take into account the fact that one in two hundred pregnancies ends in an ectopic pregnancy, a pregnancy in tube, which factually everybody would remove. That represents about 16,000 cases per year in the United States in which no Catholic hospital would hesitate to do that kind of abortion-interruption of pregnancy prior to the twentieth week. So I think one has to be careful when one says Catholic hospitals do no abortions. We do no direct abortions as perceived in moral theology. We

do do abortions in the medical sense of interrupting pregnancies prior to the twentieth week, when those pregnancies are sitting in the tube. Now why do I put in a note of caution on that point? I think the suggestion has been made that we should post on hospital walls a statement that says that this hospital, and this physician refuse to do abortions on grounds of conscience or some wording of that kind. I would like to ask of the lawyers what the implications would be of having such a notice on our walls if we did do ectopic pregnancies? Would somebody then say: you've broken your own statement of conscience. Does that have any legal implications or not? So it is not something I like to see us rushing into because you don't want to hamper our ability to at least deal with the ectopic pregnancy. Now in terms of our doing abortions of other kinds, I think we can by and large probably get away without doing these. I have predicted, in print, that the first case that will be tried will be a lady twelve weeks pregnant, poor, in a town where the Catholic hospital is the only one. Why do I say twelve weeks? Because it will be said in the court that if this isn't done at once she will fall in the thirteen week category in which case the procedure becomes more dangerous and she is, in other words, in jeopardy of her life by virtue of it not being done immediately. I have suggested flippantly that we set up a hospital travel fund so that, if such a case hits, we ship it out and pay if necessary for the poor person, the trip to the next hospital. In general, let me say one other thing, which is that one of the key issues that needs to be thought about, and it will be a long term debate, is the dangers and the perniciousness involved in the World Health Organization's definition of "health". It's something to which I heartily subscribed in one of my do-good liberal 1950 days in which I was all gung-ho on being everybody's brother. When you begin to think that through, as to what the implications are for the use of medical technology to insure a sense of well-being, then it's like saying you're in the business of trying, through medical technology, to create a discomfort-free society. This would, I think, perfectly justify abortion, deception to keep patient's comfort, wholesale drugs to keep patients' comfort, euthanasia, etc.

In brief, I have come to the conclusion that the only discomfort-free situation is death. I hope these comments have been of some help in your deliberations.