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Mahesh Ananth, Ph.D.

Teaching OB/GYN Residents Bioethics Within a Catholic Healthcare Context
Andrew Steele, M.D., FACOG

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Medical Malpractice Web Advertising: A Qualitative, Cross-sectional Analysis of Plaintiff Medical Malpractice Firms In Suffolk County, Massachusetts
Comeron W. Ghobadi, M.D. et al.

VERBATIM

Proceedings of the Matthew Bulfin Educational Conference Chicago, Illinois, September 29 - October 1, 2017
American Association of Pro-Life Obstetricians & Gynecologists and the American College of Pediatrians

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Preface

This edition features an essay by professor Ananth Mahesh, Ph.D., on the use of casuistry in medical decision-making. Albert Jonsen and Stephen Toulmin argued that the best way to resolve the complex issues in medical settings is to focus on the actual details of cases and then determine what to do in given cases. This approach to medical decision-making, labeled "casuistry," has met with much criticism. In response, Carson Strong attempted to save much of Jonsen and Toulmin's version of casuistry. This analysis reveals that Strong's recent salvage efforts fail to deflect the major criticisms. The author concludes that Jonsen and Toulmin's version of casuistry is not an appropriate framework from which to resolve complex issues in clinical settings.

The second article in this edition, by professor Andrew Steele, M.D., examines the challenges in teaching Catholic healthcare ethics to medical OB/GYN residents. Residents in the specialty of Obstetrics and Gynecology often have misconceptions as to what medical interventions Roman Catholic healthcare institutions prohibit, and why certain restrictions are placed on the provision of reproductive health options that are otherwise legally available to women. First, this article clarifies areas of conflict and convergence between Catholic and secular reproductive ethics, which are unique to OB/GYN training. Second, a rationale for incorporating Catholic healthcare ethics into an ethics curriculum for OB/GYN residents is discussed. Finally, guidelines for faculty teaching Catholic healthcare ethics are presented.

Medical student Toni Saad, in the third article, describes and evaluates the Belgian euthanasia experience by considering its practice and policy, both before and after the formal decriminalization of euthanasia in 2002. The pre-legal practice of euthanasia, the evolution of euthanasia legislation, criticism of this legislation, the influence of politics, and later changes to the 2002 Act on Euthanasia are discussed, as well as the subject of euthanasia of minors and the matter of organ procurement. It is argued that the Belgian euthanasia experience is characterized by political expedition, and that the 2002 Act and its later amendments suffer from practical and conceptual flaws. Illegal euthanasia practices remain a concern in Belgium, something which nations who are seeking to decriminalize euthanasia should consider.

In the fourth article, professors Comeron W. Ghobadi, M.D. et al., discuss the role medical malpractice plaintiff firms play in the prosecution of malpractice claims. There have been limited studies of the online advertising practices of plaintiff medical malpractice firms. This study focused on plaintiff medical malpractice firms in Suffolk

County, Massachusetts. Seventy-seven percent of law firms advertised medical malpractice awards, with Martindale-Hubbell, AVVO, and Super Lawyer being the three most common. The second most common method of advertising was accomplished through descriptions of successful verdicts and settlements (61%). A total of 408 verdicts, settlements, and arbitrations collectively representing $1.4 billion dollars were advertised by all law firms. Median awarded values for verdicts was advertised as $4.5 million, while the median awarded values for settlements was $1.25 million. Defendants most commonly practiced obstetrics (18%), followed by primary care (14%). Law firms report treatment and diagnosis delay as the most common successful claim (50%), followed much further by misdiagnosis (8%), and communication error (4%). This sample correlates with larger claims-based studies surrounding the most commonly sued specialties, however, median reported settlement and verdict values were significantly higher in this study. The authors recommend that advertising guidelines be developed for medical malpractice plaintiff firms.

The *Verbatim* section includes papers to be presented at the Matthew Bulfin Educational Conference in Chicago, Illinois, September 29-October 1, 2017, sponsored by the American Association of Pro-Life Obstetricians & Gynecologists and the American College of Pediatricians. These articles, essays, and presentation outlines include the following topics among others: Lives with disabilities worth living; 3-parent embryos and gene edited babies; surrogacy and reproductive ethics; grief, bereavement, and stress as a result of reproductive losses; conscientious objection to referral for contraception and abortion; the abortion agenda in Africa; the menstrual cycle as a vital sign; gender dysphoria in children; healthcare and Planned Parenthood; the abortion-breast cancer link and recent studies from Asia; and the limited practical effect on State laws of overturning *Roe v. Wade*, should that ever occur.

This fall edition concludes volume 32 of *Issues in Law & Medicine*.

Barry A. Bostrom, J.D.
Editor-in-Chief

Articles

Clinical Decision-Making: The Case Against The New Casuistry

Mahesh Ananth, Ph.D.*

ABSTRACT: Albert Jonsen and Stephen Toulmin have argued that the best way to resolve the complex issues in medical settings is to focus on the actual details of cases and then determine what to do in the given cases. This approach to medical decision-making, labeled "casuistry," has met with much criticism. In response, Carson Strong has attempted to save much of Jonsen and Toulmin's version of casuistry. This analysis reveals that Strong's recent salvage efforts fail to deflect the major criticisms. The upshot of this analysis is that Jonsen and Toulmin's version of casuistry is not an appropriate framework from which to resolve complex issues in clinical settings.
Key Words: **Casuistry, moral judgments, medical decision-making, paradigm cases**
***Discipline/Topic*: Bioethics/Medical Casuistry**

That advances in the biological sciences coupled with progress in medical technology have had and continue to have profound effects on both ends of the spectrum of life is fantastically clear. It is safe to say with some confidence that medical advances have put both medical professionals and those patients and families that may be the recipients of recent biomedical gains in the position of making decisions that range over bringing about life, sustaining life, and terminating life.[1]

Despite this wealth of medical knowledge and the concomitant advances in medical technology that continue to come our way at groundbreaking speed, decisions regarding how to employ or whether or not to employ such knowledge and technology to actual medical situations/cases has proven to be a notoriously difficult task. The moral status

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[1] Consider the advances in the field of synthetic biology, where new species can be created in the laboratory. For more on the moral and political dimensions of this budding science, *see* Ananth, Mahesh. 2014. Review of Kaebnick and Murray, eds., Synthetic Biology and Morality: Artificial Life and the Bounds of Nature. 2013. *Journal of Value Inquiry.* DOI 10.1007/s10790-014-9432-2.

of many of the decisions made by medical practitioners, employing various sorts of medical technology, at all regions of the spectrum of life, has come under a great deal of scrutiny in the last thirty years. More specifically, it is the moral reasoning of medical practitioners in medical settings that has been "under the moral microscope" as a result of the decisions that have been and continue to be made in the wake of our current frenzy of scientific and medical headway.

Today, three broad procedures or methodologies are being employed by bioethicists and clinicians to address the many complex medical decisions that are now part of our "brave new world." First, there is the theory school of medical ethics. Those who pledge allegiance to this camp apply general moral theories (e.g., utilitarianism, contractarianism, virtue ethics, deontology, etc.) to the specific problems that have emerged as a result of the advances made in medical and biological research (e.g., organ transplantation, gene manipulation, fetal tissue research, euthanasia, abortion, etc.). The second method for resolving decisions in clinical settings is the principle approach. Those who embrace this method eschew the difficulties associated with constructing a moral edifice, but move directly to a set of principles (e.g., autonomy/self-rule, beneficence, justice, rights, nonmaleficence, probity, etc.) that are applied to particular biomedical cases. Then, justification is given as to why a particular subset of these principles and the corresponding weight and hierarchy attached to each principle within a chosen subset is appropriate to the case at hand.[2] The third methodology, which is comprised of a few variations, is what is called the case-based or casuistic method of moral decision-making

[2] The exemplars of this camp are Beauchamp, Tom and James Childress, eds. 1989. *Principles of Biomedical Ethics*. Third Edition. New York: Oxford University Press. For a critique of this approach, see Clouser, K. Danner and Bernard Gert. 1990. A critique of principlism. *The Journal of Medicine and Philosophy*. 15.2: 219-235 and Green, Ronald. 1990. Method in bioethics: A troubled assessment. *The Journal of Medicine and Philosophy.* 15.2: 179-197. I have not included pragmatism as a distinct methodology within bioethics, because many of its faces are quite akin to either (or both) principlism or casuistry (or vice versa). Of course, much more would have to be offered to defend this claim successfully. I have not the luxury to do so in this essay. Nonetheless, in an attempt to distance themselves from principlism and casuistry *and* lay claim to a unique methodological framework for bioethics, a host of "new pragmatists" have taken both principlism and casuistry to task. Yet, Arras makes the point quite nicely when he says that the claims offered by the new pragmatists are "anything but clear. As it has been since the very beginning of American pragmatism, there appear to be several distinct versions vying for our attention and allegiance…" *See* Arras, John. 2002. Pragmatism in bioethics: Been there, done that. *Social Philosophy and Policy*. 19.2: 30. For more on the recent renaissance in pragmatism as a distinct methodology in clinical decision-making, see Arras, John. 2001. Freestanding pragmatism in law and bioethics. *Theoretical Medicine and Bioethics*. 22.2**:** 69-85; McGee, Glenn. 1999. Pragmatic method in bioethics. In *Pragmatic Bioethics*. Nashville: Vanderbilt University Press. 18-29; Miller, Franklin, Joseph Fins, and Mathew Bachetta. 1999. Clinical pragmatism: A model for problem solving. In *Pragmatic Bioethics*. Nashville: Vanderbilt University Press. 30-44; and F. Miller, J. Fins, and M. Bachetta. 1996. Clinical pragmatism: John Dewey and clinical ethics. *Journal of Contemporary Health Law and Policy*. 13.1**:** 27-51; Jansen, Lynn. 1998. Assessing clinical pragmatism. *Kennedy Institute of Ethics Journal*. 8.1**:** 23-36; Wolf, Susan. 1994. Shifting paradigms in bioethics and health law: The rise of a new pragmatism. *American Journal of Law and Medicine*. 20.4: 395-415.

in medical settings.[3] Adherents of this practice insist that both of the first two methods, the theory approach and the principle approach, are not at all efficacious (by themselves) in resolving concrete problems in clinical settings. Rather, casuists declare firmly that the only way to resolve the complex issues in medical settings is to focus simply on the actual details of specific cases and then determine what to do in the given cases.

This essay will focus on the casuistic approach. To make this inquiry tractable, after providing a brief historical backdrop for this discussion, I will provide an account of a version of casuistry offered by Jonsen and Toulmin (hereafter JT). Next, I will provide some of the central criticisms of this approach that would appear to render it rather moribund. I will then explain and evaluate Carson Strong's recent attempt to defend the JT strategy. My analysis will reveal that Strong's defense of the JT version of casuistry is not nearly as puissant as he purports.[4] The upshot, which includes two overlooked criticisms, will make clear that JT's version of casuistry is inadequate as a serious methodological framework from which to make difficult decisions in clinical settings.

Historical Background

It is no secret that moral theorists disagree vehemently as to what constitutes the correct framework from which to evaluate what kinds of acts are good and what kinds of acts are bad. As Richard Brandt quite succinctly notes: "A problem that has vexed philosophers from the very beginning is how to determine the truth or justification of normative beliefs, especially whether a certain kind of action is *morally wrong* or *morally permissible*."[5] There are radically different ways of making moral judgments. The renaissance of casuistry[6] or case-based reasoning during the 1980s can be viewed as a response to this lack of general agreement on the part of moral theorists.

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[3] For a concise overview of each of these variations of casuistry, see the following: Kuczewski, Mark. 1994. Casuistry and its communitarian critics. *Kennedy Institute of Ethics Journal*. 4.2: 99-116; Kuczewski, Mark. 1997. *Fragmentation and Consensus*. Washington, D.C.: Georgetown University Press; Kuczewski, Mark. 1998. Casuistry and principlism: The convergence of method in biomedical ethics. *Theoretical Medicine and Bioethics*. 19.6: 509-524. For some of the original works, see Jonsen, Albert and Stephen Toulmin. 1988. *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley: University of California Press.; Brody, Baruch. 1988. *Life and Death Decision Making*. New York: Oxford University Press.; Strong, Carson. 1999. Critiques of casuistry and why they are mistaken. *Theoretical Medicine and Bioethics*. 20.5: 395-411.

[4] Surprisingly, there has been little critical response to Strong's intriguing analysis. Additionally, Coleman, Kari Gwen. 2007. Casuistry and computer ethics. *Metaphilosophy*. 38.4: 471-88 has attempted to draw on the insights from medical casuistry and employ them in the field of computer ethics. Moreover, Cherry, Mark J., and Ana S. Iltis, eds. 2007. *Pluralistic Casuistry: Balancing Moral Arguments, Economic Realities, and Political Theory*. Dordrecht: Springer, have edited a collection of essays that attempt to navigate a "pluralistic" rendering of casuistry distinct from the JT and Strong renditions. Finally, hints of salvaging some version of casuistry can also be found in some of the essays edited by Rasmussen, Lisa, ed. 2005. *Ethics Expertise: History, Contemporary Perspectives, and Applications*. Dordrecht: Springer. These works are a reminder that casuistry has not at all disappeared from the ethics landscape.

[5] Brandt, Richard. 1996. Science as a basis for moral theory. In *Moral Knowledge? New Readings in Moral Epistemology*. New York: Oxford University Press. 200-214.

[6] Note that I will not here discuss the history of the concept of casuistry that emerged out of the early Middle Ages as an attempt to apply Christian religious doctrines to particular situations. For some inter-

Indeed, the traditional "top-down" approach taken by medical ethicists is to insist that some ethical theory must be constructed and then employed in determining what medical actions are morally permissible to pursue. For example, deontology/Kantianism and consequentialism are two traditional moral theories that offer quite different substantive procedures for determining what is a good or bad thing to do. Notably, such determinations of morally good and bad actions do not rely on particular scenarios, examples, or events. Rather, these moral theories rely on the rational construction of a monolithic measure of value that is decisive for all human agents, irrespective of their particular circumstance. In short, many moral theorists insist that theory guides what one ought to do in particular scenarios and not vice versa. For example, Immanuel Kant most forcefully notes the primacy of theory over circumstance. He says:

> Worse service cannot be rendered morality than that an attempt be made to derive it from examples. For every example of morality presented to me must itself first be judged according to principles of morality in order to see whether it is fit to serve as an original example, i.e., as a model. . . . Examples serve only for encouragement, i.e., they put beyond doubt the feasibility of what the law commands and they make visible what the practical rule expresses more generally. But examples can never justify us in setting aside their true original, which lies in reason, and letting ourselves be guided by them. . . Such a procedure turns out a disgusting mishmash of patchwork observations and half-reasoned principles in which shallowpates revel because all this is something quite useful for the chitchat of everyday life.[7]

It is rather difficult to mistake Kant's points in the above quotation: The foundation of morality cannot reside in the details of human activities because (1) one must first have some "moral principle" in mind in order to judge that a particular example is an appropriate example, (2) examples only serve to reveal the applicability of a moral theory and the practical principles that are generated from such a theory, (3) examples cannot be used as a justification for eliminating the moral theory/principles from which these examples were determined to be moral examples, and (4) if examples are used in place of a moral theory, then the result will be rather emaciated moral principles due to poor observations and flawed reasoning inherent in people. For Kant, then, examples merely reinforce and motivate one to embrace a moral theory that is in no way grounded in examples.

This theory-driven approach,[8] the emphasis on a common or univocal view of the good, however, has supposedly fallen out of favor as of late, especially by many of

esting discussions of the history of casuistry, see A. Jonsen and S. Toulmin. *Supra* note 3; Keenan, James and Thomas Shannon, eds. 1995. *The Context of Casuistry*. Washington, D.C.: Georgetown University Press.; Leites, Edmund. 1974. Conscience, casuistry, and moral decision: Some historical perspectives. *Journal of Chinese Philosophy*. 2.1: 41-58; Biggar, Nigel. 1989. A case for casuistry in the church. *Modern Theology*. 6.1: 29-51.; Mehl, Peter. 1996. William James's ethics and the new casuistry. *International Journal of Applied Philosophy*. 11.1: 41-50.

[7] Kant, Immanuel. 1993. *Grounding for the Metaphysics of Morals*. Third Edition. James W. Ellington, trans. Indianapolis: Hackett Publishing Company, Inc. 20-21.

[8] Jonsen, Albert. 1991. American moralism and the origin of bioethics in the United States. *Journal of Medicine and Philosophy*. 16.1: 113-130, has called this theory-driven approach "secular fundamentalism."

those in the field of bioethics. Daniel Callahan quite nicely describes the contemporary "moral atmosphere" that has fueled this resistance to and skepticism of moral theorizing that is at its apogee today:

> The most striking change over the past two decades or so has been the secularization of bioethics. The field has moved from one dominated by religious and medical traditions to one increasingly shaped by philosophical and legal concepts. The consequence has been a model of public discourse that emphasizes secular themes: universal rights, individual self-direction, procedural justice, and a systematic denial of either a common good or a transcendent individual good.[9]

This cloud of moral skepticism has been made manifest in bioethics in the form of what John Arras has called "The New Casuistry."[10] Before diving into the details of this discussion, however, I must explain more fully the procedural details of this "New Casuistry." It is these fine points of casuistry, through the work of JT, to which I now turn.

The JT Brand of Casuistry

In what can be viewed as a direct reaction against the principle approach and Kant's rejection of empirical facts about the human condition (i.e., examples) as guides to morality and moral judgment, Toulmin responds as follows:

> In ethics, moral wisdom is exercised not by those who stick by a single principle come what may, absolutely without exception, but rather by those who understand that, in the long run, no principle—however absolute—can avoid running up against

[9] Callahan, Daniel. 1990. Religion and the secularization of bioethics. *Hastings Center Report*. 20. Supplemental: 2. Similarly, Audi claims, "[r]eflective people who want moral guidance have often noted that the help they get from moral theories, particularly Kantianism and utilitarianism, is quite limited. From Kant's categorical imperative or Mill's principle of utility, for instance, there is often a long, uncharted distance to moral decision…virtue ethics seem to their critics unclear in application to action, lacking in principles needed to justify moral decisions, or at best derivative from rule theories…many philosophers regard intuitionism as dogmatic or consider it inadequate because it lacks a comprehensive moral theory as a basis for its disparate principles. It also shares with virtue theories—and arguably with other rule theories—great difficulties in providing a way to resolve conflicts of duties…" *See* Audi, Robert. 2001. A kantian intuitionism. *Mind*. 110.439: 601. For an attempt to resolve this problem between moral theory and medical practice, see "The Wide Reflective Equilibrium" methodology offered by Kushner, Thomasine, Raymond Belliotti, and Donald Buckner. 1991. Toward a methodology for moral decision making in medicine. *Theoretical Medicine*. 12.4: 281-293.

[10] Arras, John. 1991. Getting down to cases: The revival of casuistry in bioethics. *The Journal of Medicine and Philosophy*. 16.1: 30. Of course, casuistry has not been the only contender to the theory approach. Indeed, the Callahan quotation might best capture the principle approach to bioethics offered by Beauchamp and Childress, *supra* note 2. The point here is to make clear the shift away from ethical theory. Nonetheless, this change in the moral landscape has also been thought by some commentators to be caused by the attention given by moral philosophers to the various decisions made in the field of medicine itself. This change of focus was a counter-response to the shift to metaethics that dominated most of moral philosophy in the first half of the twentieth century. *See* Toulmin, Stephen. 1988. The recovery of practical philosophy. *The American* Scholar. 57.3 (Summer): 337-352.; Toulmin, Stephen. 1982. How medicine saved the life of ethics. *Perspectives in Biology and Medicine*. 25.4: 735-750.; Toulmin, Stephen. 1981. The tyranny of principles. *The Hastings Center Report*. 11.6: 31-39.

> another equally absolute principle; and by those who have *experience* and *discrimination* needed to balance conflicting considerations in the most humane way.[11]

Jonsen offers much the same reply as Toulmin when he claims the following:

> Circumstances are not, as the etymology of the word suggests, things that 'stand around'; they are as integral to the moral analysis as are principles. . . Moral judgment is a patterned whole into which principles, values, circumstances, and consequences must be fitted. The particular judgment itself must be fitted into a larger set of judgments about moral suitability of behavior and practice.[12]

It should be evident from the above two passages that JT embrace the very element that Kant thought was extremely deleterious to moral judgment. That is, JT insist that the particular details, events, and circumstances (i.e., "examples" in Kant's framework) that make up human existence are ineliminable as a means of producing particular moral judgments. Notice that this method of moral reasoning does not rely on abstract principles (e.g., Kant's Categorical Imperative or Utilitarianism's "greatest happiness for the greatest number"), but rather it "consists of thinking and talking about how the circumstances of this or that case of moral perplexity fit the general norms, rules, standards, and principles of morality. This is casuistry in life."[13]

Of course, all of this is rather vague, and provides very little in terms of understanding casuistry as a procedure for determining what to do in particular circumstances. Fortunately, JT provide seven features that capture their version of casuistry. They are as follows:

1. Similar type cases ("paradigms") serve as final objects of reference in moral arguments, creating initial "presumptions" that carry conclusive weight, absent "exceptional" circumstances.
2. In particular cases the first task is to decide which paradigms are directly relevant to the issues that each [paradigm] raises.
3. Substantive difficulties arise, first, if the paradigms fit current cases only ambiguously, so the presumptions they create are open to serious challenge.
4. Such difficulties arise also if two or more paradigms apply in conflicting ways, which must be mediated.

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[11] S. Toulmin. The tyranny of principles. *Supra* note 10: 34 (emphasis added). A variation of this resistance to moral theorizing is offered by Jonsen, Albert. 1991. Of balloons and bicycles; or, the relationship between ethical theory and practical judgment. *Hastings Center Report*. 21.5: 15. He says: "The weight of any ethical consideration comes, not from the principles or maxims invoked, but from the more fact-like considerations that are piled onto practical judgment." *Also, see* Kymlicka, William. 1996. Moral philosophy and public policy: The case of new reproductive technologies. In *Philosophical Perspectives on Bioethics*. Toronto: University of Toronto Press. 244-270. His analysis of reproductive technologies and public policy suggests that he would side with both Toulmin and Jonsen. Note, however, that Jonsen appears to be more sympathetic to the concerns of the moral theorist than is Toulmin.

[12] Jonsen, Albert. 1996. Morally appreciated circumstances: A theoretical problem for casuistry. In *Philosophical Perspectives on Bioethics*. Toronto: University of Toronto Press. 40 and 45.

[13] Jonsen, Albert. 1995. Casuistry: An alternative or complement to principles? *Kennedy Institute of Ethics Journal.* 5.3: 237.

5. The social and cultural history of moral practice reveals a progressive clarification of the "exceptions" admitted as rebutting the initial moral presumptions.
6. The same social and cultural history shows a progressive elucidation of the recognized type cases themselves.
7. Finally, cases may arise in which the factual basis of the paradigm is radically changed.[14]

In what follows and for the scope of this essay, I will provide an explanation of elements 1-4 of JT's casuistic approach by means of two examples. This will suffice to give the reader a clear sense of their casuistic method.

To begin, much like Aristotle did,[15] JT claim in their first point that there are acts or scenarios (i.e., paradigm cases) that are obviously good or bad, which are used as reference points to assess the goodness or badness of other acts. The closer a given case resembles the paradigm case, the more reason one has for resolving the given case like the paradigm case. The following two cases will help make clear how to understand JT's analysis. They are as follows:

Case One: The Foot-Stabbing Nurse

Imagine a nurse who randomly stabs his terminally ill cancer patients under their feet with an empty syringe simply for the enjoyment of watching them scream. Plead as they will, the nurse pays no attention to them and continues to inflict much pain on these people, who are unable to fend for themselves due to their many ailments. The nurse's only reply to the supplications of his cancer patients is, "What does it matter to you? You will be dead soon anyway."

Case Two: The Cleaning Nurses

Imagine another case in which a 70-year-old bed-ridden patient named Mary is diagnosed with a severe case of osteoporosis, and is currently on full oxygen support. Moreover, it is feared that she will not live for more than two years. Mary demands (in writing because she cannot speak with the breathing tube down her throat) that the cleaning of her oxygen apparatus be stopped. She insists that such cleaning is excruciatingly painful and earnestly entreats the nurses and doctor(s) to stop. The medical staff pays no heed to the patient's request and continues to clean her breathing apparatus on the hour, by the hour. The medical staff, as well as the patient, knows that death will be hastened, if this cleaning is not continued, in light of the patient's acute respiratory condition. In fact, as a final resort, Mary exclaims (in writing of course) in response to the continued cleaning of her breathing apparatus, "You might as well stab syringes in

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[14] A. Jonsen and S. Toulmin. *Supra* note 3, at 306-07.

[15] Aristotle says: "not every action nor every passion admits of a mean; for some have names that already imply badness, e.g., spite, shamelessness, envy, and in the case of actions adultery, theft, murder; for all of these and suchlike things imply by their names that they are themselves bad. . . It is not possible, then, ever to be right with regard to them; one must always be wrong." *Nicomachean Ethics*. Second Edition. 1999. Terence Irwin, Trans. Indianapolis: Hacket Publishing Company, Inc. Book II, ch. 2, 1107a9-15.

my foot!" Finally, the medical staff consents to Mary's wish. After a week, Mary dies of respiratory failure due to lung tissue deterioration.

Mary, the border-line terminally ill patient in Case Two, appears to be suggesting that her current plight is no different than that of those patients who are victims of the foot-stabbing nurse in Case One. Put another way, the actions of the nurses who are caring for Mary are morally indistinguishable from the actions of the foot-stabbing nurse, argues Mary. Is this possible? Put differently, are the nurses committing a violent act against a defenseless person, as the foot-stabbing nurse does against his patients? Should these nurses be punished like the foot-stabbing nurse?

No doubt, it is the case that Mary is defenseless. She barely has enough strength, given her respiratory difficulties and other physical ailments, to do anything more than write a few lines on a piece of paper. Both she and the medical staff agree on this point. The two parties part company, however, on their views about the moral status of the actions of the nurses. From the medical staff's perspective, the pain caused by the medical care they provide cannot be helped. Phlegm build-up in the breathing tube, they argue, makes breathing very difficult and will eventually render breathing impossible if left unattended. If the long-term benefits of comfortable breathing for the patient are to be ensured, the cleaning procedures must be continued, despite the accompanying suffering.

The patient's riposte, however, to the medical staff is that she is terminally ill. She suffers enough with her more pressing osteoporosis. This palliative care and its corresponding pain only increase her overall suffering. Even if a lack of care of the breathing tube increases the likelihood of respiratory failure, the patient insists that such maintenance must cease. The patient makes it clear in no uncertain terms that a hastened death is far superior to the hourly torture of breathing-tube cleaning. From the patient's perspective, then, to continue with this care in the face of her protestations is as wicked as the actions of the foot-stabbing nurse.

Let us now employ JT's casuistic approach to help resolve what is, admittedly, a rather contrived set of cases. Note that Case One is designed to capture the first of the seven elements stated above. It is supposed to be one of those cases that is obviously morally bad and will be referred to as "demarcation cases." As JT determine, these kinds of cases "are the markers or boundary stones that delimit the territory of 'moral' considerations in practice."[16]

First, we would want to know what criteria JT employ for determining what cases are obvious demarcation cases which "serve as final objects of reference in moral arguments."[17] In fact, they provide the following four "factors" (for lack of a better term), which generate what are presumed to be morally bad cases:

(1) willful physical harm/violence [against innocent and defenseless people];

[16] A. Jonsen and S. Toulmin. *Supra* note 3: 307.

[17] Now one might think it is odd that there would be criteria to which JT want to appeal. Specifically, it seems like if JT are allowed to appeal to criteria as exemplifying the demarcation cases, why would not the criteria, rather than the demarcation cases, be the point of interest for ethicists? The upshot of this query would be that one would not need to depend on casuistry *qua* actual cases. One would have higher

(2) disloyalty to one's community;
(3) deception by lying;
(4) inconsiderate behavior toward another.[18]

Case One is of the sort that JT would consider being an obviously immoral act because it is a presumed case of "violence against innocent *defenseless* human beings."[19] In fact, such a case is so obviously morally degenerate that JT claim that "[n]o complex moral argument is needed to demonstrate that [it] is wrong."[20]

I will now explain features 2, 3, and 4 of JT's brand of casuistry (p. 149) in what follows, and will use Case Two, The Cleaning Nurses, for assistance. With regard to 2, we need (a) to determine what salient issues arise in this particular case so that (b) it is then possible to provide the paradigms relevant to the case. Of course, Jonsen is well aware that difficulties will arise in making such determinations and suggests what these difficulties might look like in features 3 and 4. First, then, how are we to determine the salient issues? Although not specified in detail in JT's groundbreaking *Abuse of Casuistry*, Jonsen has provided in his more recent efforts three concepts—(1) morphology, (2) taxonomy, and (3) kinetics—that are designed to answer this question.

Morphology

The morphology of a case consists of (a) descriptive elements, (b) maxims, (c) a structure, and (d) a substructure. The descriptive elements of a case include the "who, what, when, where, why, how, and by what means."[21] For example, in Case Two the descriptive elements would include the relationship between the medical staff and the patient, the current status of the terminal illness of the patient, the nurses' actual routine of cleaning the patient's breathing tube, the mental and physical distress of the patient, the patient's request for the termination of the cleaning of her breathing tube, the death of the patient, etc.

The maxims or important propositions related to Case Two could be "patient requests should be honored based on autonomy," "killing is strictly prohibited by medical practitioners," "relief of pain is the medical practitioner's main focus in caring for a terminally ill patient," etc.

The structure of a case includes both (i) the interplay between the descriptive elements of a specific case and the various relevant maxims and (ii) the structure of moral

principles guiding moral judgments, and one could simply assess these principles rather than the cases. In my critical section, I will return to this concern.

[18] A. Jonsen and S. Toulmin. *Supra* note 3: 306-307.

[19] *Ibid.*, 307-308 (emphasis added).

[20] *Ibid.*, 308. The example that JT use is that of child abuse. What, however, actually constitutes child abuse—from strong verbal reprimands to actual physical punishments—is a highly contentious issue. Nonetheless, we can assume that they are referring to cases of parents punishing their children through the use of a hot iron, for example. They seem to be suggesting that regardless of the details, such an act of punishment of a child on the part of any parent would be deemed morally unacceptable behavior.

[21] Jonsen, Albert. 1991. Casuistry as methodology in clinical ethics, *Theoretical Medicine* 12.4: 298. Note that Jonsen employs the famous "Debbie Case" to explain his views. *See* Anonymous 1998. It's over, Debbie. *Journal of the American Medical Association* 259.14: 272.

reasoning germane to a particular case. With regard to (i) and Case Two, it is the job of the casuist to figure out which maxims and descriptive elements are most pertinent to Mary's case (I will return to this point). Moreover, Jonsen claims that (ii) is a kind of reasoning that is "an invariant pattern of reasoning in which certain claims are related to grounds, warrants, backing, and modal qualifiers."[22] The moral reasoning in particular cases can be understood to have the following form:

> I *judge* that person(s) V should or should not perform act(s) W *because* of reason(s) X, *unless* circumstance(s) Y bears on the case Z.

Case Two, for example, might appear like this:

> I *judge* that the nursing staff should stop their breathing tube cleaning routine as Mary has requested *because* of the unbearable pain it causes her and the fact that she is terminally ill, *unless* there is a change in her diagnosis.

So, what Jonsen calls "the structure of practical discourse"[23] includes a moral claim(s), the moral claim's corresponding justification, and qualifications that might render the moral judgment inapplicable to the case.

Finally, the substructure of a case is "the invariant patterns of discourse." This element of morphology is what Jonsen calls the "topics" or "loci" that "provide familiar ground amidst the variable, complex circumstances of particular cases. Regardless of the specific content of the case (the circumstances), the forms of argument called topics remai[n] invariant."[24] The kinds of topics to which Jonsen is referring include both general and specific topics. The general topics include: physical causation vs. moral causation, killing vs. letting die, intention vs. foresight. These are topics that could be relevant to basically any act performed by an agent. The more specific topics involve: quality of a patient's life, preferences of the patient, economic considerations, and a patient's current clinical condition. These specific topics revolve around the details that relate to the particular medical condition of a patient. We could imagine that all of this substructure could be included in Case Two. That is, if the nurses do abide by Mary's wishes, they either killed her or let her die; they either did or did not cause her death, depending on whether an omission of care could be considered a relevant aspect of the concept of causation (either moral or medical); and they also may have intended to relieve Mary's pain, while foreseeing that she would die. With regard to the specific topics, Mary's quality of life could have been determined to be extremely poor; her preferences were made quite clearly to the medical staff; Mary is quite poor and is being financially supported by the state; and her clinical condition is that she has osteoporosis that has reached an advanced stage—that is, she is terminally ill and has no more than two years to live.

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[22] A. Jonsen. *Supra* note 21: 299.
[23] *Ibid.*, 299.
[24] *Ibid.*, 300.

Taxonomy

The second aspect of Jonsen's elaborated casuistic procedure is taxonomy. Taxonomy refers to the general "lineup" of cases to which a specific case will be compared. This lineup of cases includes a paradigm case that is generally agreed upon by most people to be morally wrong or right. The paradigm case is a case in which the maxim governing it is clearly thought to be correct with few people objecting to the chosen maxim. Additional cases are added with different circumstances to form a lineup of cases. These additional cases, which deviate from the original obvious paradigm case due to their different circumstances, are also judged to be morally good or bad cases. After a sufficient number of cases and the relevant moral judgments about the cases are gathered by the casuist, she then compares her current case to the lineup of cases. Then, she determines which case in the lineup most closely mirrors or approximates her current case under examination. The moral evaluation of the case in the lineup (i.e., the moral maxim generated from the case) that most closely resembles the case under examination will be the moral evaluation of the new case.

Case Two will help illustrate Jonsen's meaning of taxonomy. To begin, we need to know what general category Case Two falls under. It could be deemed a case that fits into the lineup of cases that has to do with killing, considering that the medical staff is well aware that the termination of care would hasten Mary's death. Alternatively, Case Two might be thought of as a case that should be couched within the lineup of cases that has to do with the hiring of medical personnel, since the people who acquiesced to Mary's request are involved (to some degree) in the events that ensued. Further still, Case Two might be a case that fits into the lineup of cases that deal with care for a patient. How do we decide to which category Case Two belongs? As I understand Jonsen, the answer is that a good ethicist who is familiar with many kinds of cases and who is educated and trained well "has the knack of doing this well and of showing others how to do this."[25] So, let us accept that the skilled ethicist has judged that the first category is more plausible as the appropriate category than is the second, since Mary's premature death was the result of a lack of medical attention that otherwise would have allowed her to live longer than she did (I will have more to say about this point in the critical section of the article). So, the ethicist determines that the category of killing is the appropriate general category from which a lineup of cases can be constructed.

A lineup of cases would reveal that at one end of the spectrum of killing are completely unjustified killings and at the other end of the spectrum are completely justified killings. In the former type of case, the maxim might be: "One ought never kill a person against his will—that is, murder is strictly prohibited." In the latter type of case, the maxim could be: "One may justifiably kill a person, if it is the only means of self-defense possible." As Jonsen notes, the casuist will eventually be confronted with a case of euthanasia and must decide where on the spectrum it lies. To do this, Jonsen suggests that the casuist should ask whether (1) a patient's competent request to have

[25] *Ibid.*, 307.

certain medical procedures terminated, along with (2) the patient's intractable pain or terminal illness, are acceptable conditions that allow for the patient to be assisted in being killed. If the answer is yes, then the corresponding maxim might be: "One ought not kill another person, except in those situations of self-defense and those circumstances in which a (near) terminally ill competent patient requests assistance in dying due to unbearable suffering."

As additional cases are provided in detail, they too are fit in along this spectrum. Some of these cases will lie more at the unjustified killing end of the spectrum, while others will fall closer to the justified killing end of the spectrum. If Case Two does not seem to be a case of unjustified killing, the casuist would then compare Case Two with the paradigm case of justifiable killing and other close cases of justified killing to see where Case Two fits into this spectrum. The closer Case Two is to the paradigm case, the more justified the casuist is in prescribing a course of action in Case Two that parallels the features of the chosen case on the spectrum. Although Case Two is not a case of self-defense, it does resemble those instances of euthanasia that are thought by Jonsen to be justifiable killings. So, a casuist like Jonsen would probably conclude that the actions (or omissions) of the medical staff in Case Two were morally acceptable, given the details of the case. Let us, however, look at Jonsen's last element, kinetics, to be sure how the casuist would handle Case Two.

Kinetics

Jonsen tells us that by "kinetics" he means "the way in which one case imparts a kind of moral movement to other cases. . . the motion is a shift in moral judgment between paradigm and analogous cases, so that one might say of the paradigm, 'this is clearly wrong' and of an analogous case, 'but, in this case, what was done was justified, or excusable.'"[26] It appears that kinetics is the change in judgment that corresponds to the change(s) that are perceived in a given case when compared to the paradigm case. Restated, the casuist is looking for a certain degree of, for example, autonomy, suffering, or patient-doctor closeness when compared to the paradigm case that has the right degree of each of these elements. For example, the casuist might judge that a terminally ill incompetent person, who is suffering greatly, cannot have his request for assistance in death honored because he is not competent to the right degree (which is determined in relation to the paradigm case). It might be thought, however, that Mary in Case Two should have her wish honored, because she has all the necessary degrees of the relevant circumstances. The obvious question is: "On what basis is one able to make such a judgment across cases?" Jonsen says that the answer is through "the wisdom of experience. . . [t]his knowledge is not deduced from principles but learned from reflective experience."[27]

Again, employing Case Two might prove helpful in understanding kinetics *qua* movement from a paradigm case to another case. In Case Two, the kinetics might move

[26] *Ibid.*, 303.
[27] *Ibid.*, 304.

from a paradigm case that would address the personal autonomy of a patient and the nature of a patient's illness to a case about the degree to which a patient is competent or clinically depressed and the degree of a patient's suffering. So, the casuist might judge in Case Two that the crucial movement is from a paradigm case concerned with the nature of Mary's illness and Mary's autonomy to the degree of Mary's competency and the degree of her suffering. Then, the casuist might determine ("moving" from the paradigm case) that, although Mary is not quite terminally ill, she is ill to a great enough degree and is both competent and suffering to a high enough degree such that the decision of the medical staff to withhold care is justified.

To summarize briefly, Jonsen argues that morphology, taxonomy, and kinetics are crucial aspects of the casuistic process that fill in the details of the following features mentioned earlier:

1. In particular cases the first task is to decide which paradigms are directly relevant to the issues that each [paradigm] raises.
2. Substantive difficulties arise, first, if the paradigms fit current cases only ambiguously, so the presumptions they create are open to serious challenge.
3. Such difficulties arise also if two or more paradigms apply in conflicting ways, which must be mediated.

It appears that Jonsen's elaborated account of casuistry is designed to handle features 2-4 (p. 149). First, the casuist *qua* morphologist is able to determine the circumstances, maxims, structures, and substructure of a particular case. After determining the structure of a case, the casuist *qua* taxonomist is able to determine which cases within a lineup of cases are most relevant to a particular case at hand. This resolves the problem of competing paradigms rendering conflicting resolutions to the case at hand. These abilities of the casuist should resolve, according to Jonsen, any difficulties or objections that present themselves in 2-4. Moreover, the casuist *qua* kineticist is able to "double-check" his efforts by being able to move from the particulars of a paradigm case—specifically, the maxim(s) and concepts such as autonomy, utility, competency, etc. that are generated from it—and determine to what degree the same relevant features are present in the case under scrutiny. Indeed, Jonsen is confident enough in his version of casuistry that he thinks that it "will be able to locate the case in a taxonomy of cases, recognize the similarities and differences and appreciate the shift from moral certainty to moral doubt. Above all, casuistic reasoning is prudential reasoning: appreciation of the relationship between paradigm and analogy, between maxim and circumstances, between the greater and less of circumstances as they bear on the claim and the rebuttals."[28] With these details in place, I will turn to a few obstacles to the JT brand of casuistry (and the details Jonsen has offered) that, at the very least, will dampen the fecundity that JT attribute to their casuistic method.

[28] *Ibid.*, 306.

Criticisms of JT's Brand of Casuistry

In this section, I will provide five standard objections, which are provided by Strong, to JT's brand of casuistry.[29] In the next section, I will provide Strong's confutation to these objections and my own reply to Strong. Recall that I will conclude, despite Strong's attempted rescue, that the JT version of casuistry cannot be salvaged as a legitimate method for resolving the moral difficulties that surround bioethics cases.

To begin, JT claim that their version of casuistry "resembles its medieval and Renaissance precursors, in both substance and methods of argument."[30] The first objection is that there is no agreed-upon moral foundation for the modern secular version of casuistry defended by JT that can be effective in the way that the version of casuistry defended in the late Middle Ages was. The older version of casuistry relied on interpretations of Christian doctrine to construct paradigms and resolve disputes. For instance, there was a concern as to whether or not it is morally permissible for Christians to eat meat that was offered to false idols by non-believers. 1 Corinithians 8 does not entirely forbid the consumption of such meat, but warns that doing so with full knowledge that the meat was presented to false idols could lead oneself and others into weakness regarding religion's rule-following. In these sorts of cases where the answer is not straightforward, a follower of the Catholic faith could endorse the interpretation of scripture taken by one theologian over another, even if such a position contradicted the fathers of the church. In some cases, the consumption of such meat was allowed, while in other cases it was prohibited. Such interpretations relied on textual ambiguity (e.g., some of the writings of Paul) or absence of textual rules entirely regarding the circumstances of a particular case. In these instances, theologians offered moral guidance on a case-by-case basis, drawing upon both their own insights and how related cases were historically resolved.[31]

Given that we live in a society that is comprised of a whole host of "philosophies" that range from organized religions to secular worldviews of all sorts—which can offer fairly detailed guidelines for how to live in the world—it will be quite common that these different "ways of living" will come into conflict. Indeed, issues concerning health and life-and-death medical procedures are areas where these differences in "ways of living" are most likely to clash.[32] For example, imagine a Jehovah's Witness who chooses to

[29] C. Strong. *Supra* note 3: 404-408. I wish to make clear here that part of Strong's defense of JT's brand of casuistry is connected with his own two-paradigm version in this same article. I will not here evaluate the effectiveness of Strong's own version. Rather, in this essay, I restrict my analysis to why he thinks that the JT version should be exonerated of all but one of the criticisms leveled against it.

[30] A. Jonsen and S. Toulmin. *Supra* note 3: 306-307. For a variation on this criticism, see Wildes, Kevin. 1993. The priesthood of bioethics and the return of casuistry. *The Journal of Medicine and Philosophy.* 18.1: 36 and 43.

[31] For more on this history of Christian casuistry, see Vallance, Edmund and Harald Braun, eds. *Contexts of Conscience in the Early Modern World, 1500–1700.* New York: Palgrave McMillan.

[32] Recall the uproar over the Terri Schiavo persistent vegetative state case in Florida. For a brief reminder, see Quill, Timothy E. 2005. Terri Schiavo—A tragedy compounded. *New England Journal of Medicine.* 352.16: 1630-1633. *See also* Ananth, Mahesh. 2008. *In Defense of an Evolutionary Concept of Health* Aldershot: Ashgate Press. for a detailed account of the contentious debate surrounding the concept of health.

watch her child die rather than seek the requisite blood transfusion that would save her child's life (more on this example later). What is the paradigm case from which to judge this case? Recall that JT offer criteria that help demarcate "obviously bad" cases. Given these criteria, maybe the correct answer is that the Jehovah's Witness case is a paradigm case of "willful harm/violence to another," since the mother could have allowed the requisite medical attention to be given to her ailing child. No doubt, some people do think that there is very little moral difference between this case and the foot-stabbing nurse case as far as the notion of harm/violence is concerned. But it could be a case of "disloyalty to one's community," if the Jehovah's Witness were to allow the requisite medical treatment for her child. For she might be completely ostracized by her fellow Witnesses for contaminating her child's soul.

The point is that it is not at all clear how the JT method of casuistry can help determine which criteria should be given precedence when determining paradigm cases in such scenarios like food consumption and allowing a loved one to die. Without an authoritarian foundation or a shared morality to which most members of society are willing to acquiesce, it does not seem possible for the modern version of casuistry to provide justification for what will count as legitimate paradigms from which other cases will be judged. So, JT cannot rely on the medieval Christian version of casuistry, some critics have argued, in the context of a pluralistic society.

The second criticism, which is closely connected to the first, against the JT casuistic method is that it is not able to achieve extensive social concurrence on *all* issues. Strong claims that those who oppose casuistry insist that the supporters of this methodology think they can achieve consensus on all issues, but have failed to live up to their claims.[33] According to this criticism, casuists see themselves as offering a methodology that can resolve cases in the clinical setting that ranges over the most straightforward cases (e.g., the foot-stabbing nurse), the somewhat complicated cases (e.g., cases related to informed consent), and the most complicated cases (e.g., cases related to medical triage), because they can achieve consensus on the moral issues that lie behind this spectrum of cases. Regardless of how controversial a case may be, the casuistic method is seen by its opponents as claiming to be able to achieve unanimity amongst most people in society on all moral issues anywhere on the spectrum of cases noted here—a feat it cannot achieve in reality, claim the opponents.

The third objection against casuists is that they are unable to justify the values to which they adhere because they rely on a form of moral intuitionism—the ethical theory that certain values or moral concepts are directly known to be true through some kind of special insight or moral faculty. Specifically, Strong suggests that opponents of casuistry insist that the casuist's justification for why a particular paradigm case is thought to be the correct paradigm from which to evaluate some other case is based on

[33] Strong is referring to John Arras' critical commentary on the JT version of casuistry. *See* J. Arras. *Supra* note 10: 29-51.

an appeal to an intuition, either about the paradigm case simpliciter or about certain features of the paradigm case.

We can understand this third objection by briefly examining how JT handle the framework of the abortion case in the last chapter of their *The Abuse of Casuistry*. First, JT point out that neither conservatives nor liberals in the abortion debate distinguish the moral standing of a zygote from the moral standing of an advanced fetus. They go on to explain that the former conclude that an abortion is almost never permissible, while the latter insist that an abortion is almost always permissible. In contrast to both of these extreme views, JT insist that a more moderate middle-ground view should be embraced such that (all other details being equal) the abortion of a newly formed fetus is morally permissible in a way that the abortion of a late-term fetus is morally impermissible.

How do JT come to this conclusion? In general, they argue that the values of charity (being respectful of the details of a case) and equity (balancing one's moral decisions in the light of the details of a case) regarding the differences in the biological development of a newly formed zygote and a late-term fetus should move one to see that such differences make a moral difference. Additionally, in terms of both charity and equity, JT claim that the correct moral resolution is amplified once additional details (beyond biological development of the fetus) of a particular case of abortion are considered. For instance, if the parents of a newly pregnant thirteen year-old female insist that their daughter's pregnancy be terminated because the newly formed zygote is the product of rape, then termination of this pregnancy may very well be morally permissible once all other relevant details are in place. In contrast, if a woman chooses to terminate the life of her eight-month old fetus to spite her philandering husband, then these details (along with other details) may reveal that the desired termination is morally impermissible. As JT stress, "before we take a 'principled' stand toward particular cases of abortion, charity and equity require that we be informed about the circumstances of the particular case."[34]

In response to this account of the abortion debate, Kopelman points out that:

> conservatives and liberals also claim it is they alone who are truly charitable and equitable, and identify the relevant features embedded in the situation. The conservative finds a developing human life most significant, the liberal sees the woman's right to decide what happens to her body as most important, and the moderate sees an important value conflict requiring compromise.[35]

Kopelman's point is that even if we assume that charity and equity are the correct principles that govern the abortion debate, how these principles are applied to particular cases ends-up relying upon conflicting intuitions. For instance, as Kopelman points out above, the conservative will focus both charity and equity on the some perceived salient features of a particular case (e.g., likely long-term regret on the part of the parents and the mother or the moral innocence of the growing fetus), while the liberal will focus on a different set of perceived salient features (e.g., the autonomy of the mother or the

[34] A. Jonsen and S. Toulmin. *Supra* note 3: 337.

[35] Kopelman, Loretta M. 1994. Case method and casuistry: The problem of bias. *Theoretical Medicine*. 15.1: 32 (emphasis added).

lack of rights of the fetus relative to the rights of the mother) also employing the principles of charity and equity. *And* the moderate will choose a yet distinct set of perceived salient features (e.g., age of pregnant person and/or the origin of the pregnancy) via the principles of charity and equity. It is JT's inability to reconcile these conflicting sets of perceived salient features valued by these different camps in the abortion debate that moves Kopelman to conclude that JT's "*intuitions* about what is relevant, charitable and equitable, therefore, do not settle the abortion debate."[36]

The fourth objection to casuistry that is noted by Strong is that conflicting paradigm cases can always legitimately be generated so as to produce different conclusions about what to do in a given case. The result is that a medical practitioner is left paralyzed regarding what to do in a given case. For instance, what would be the correct paradigms under which an infant with anencephaly—that is, an infant born with large sections of its cranium, forebrain, and brainstem missing—would be evaluated for medical treatment, given that the mother of the child insists that the child receive medical care to the fullest extent? Would paradigm cases of justified killing be invoked if it were deemed a futile case? If so, the result would be the death of a child partially due to the omission of treatment on the part of the medical staff. Maybe, however, the correct paradigm cases are those in which proxy decision-making (in this case, the proxy is the mother of the child) is observed. If so, then all medical means would be provided with the result that the child lives a few days. Notice that despite the fact that the outcome—the death of the child—is the same, regardless of which decision is followed, the actions themselves are radically different. Under one set of paradigms, life-sustaining medical care is provided to the child. Under a different set of paradigms, the child receives no medical attention. The point, as far as this criticism is concerned, is that medical practitioners are left bewildered as to what to do, given the results of the different paradigms. So, practically speaking, casuistry is considered by some to be ineffectual in clinical settings.[37]

The final objection against casuistry is that "casuists cannot articulate the grounds of their decisions. Specifically. . . when casuists assert that a given case is close enough to [a] paradigm case to be decided in the same way as the paradigm, there are no fully articulated grounds for that judgment."[38] I take the criticism here to be that of a threshold problem—that is, it is not clear how many features or what percentage of the relevant features of a case under evaluation must be shared with the chosen paradigm case. As Strong makes clear, JT provide no help on how to determine what the line of demarcation would be. This justificatory silence on the part of JT even has one of their champions (namely, Strong himself) admitting that "it is not clear to me how Jonsen's

[36] *Ibid.*, 337.

[37] As Tomlinson puts it, "the appeal to paradigm cases assumes that the proper ones have been selected for comparison, and in any contentious ethical question, where there are competing ethical considerations or maxims, there will also be alternative sets of paradigm cases to which analogies can be drawn." *See* Tomlinson, Tom. 1994. Casuistry in medical ethics: rehabilitated or repeat offender? *Theoretical Medicine*. 15.1: 13.

[38] C. Strong. *Supra* note 3: 407.

approach can be defended against this objection."[39] Given that Strong thinks that this objection cannot be overcome by the JT approach, it is reasonable to turn to Strong's defense of JT's version of casuistry against the first four objections and the reasons why his attempt to deflect them is unsuccessful.

A Rejoinder to Strong's Salvage Effort

Assessment of Objection #1

Now that we have what Strong takes to be the objections to casuistry, we can consider his defense of JT's version of casuistry against the first four criticisms. He says in reply to the first objection, which is the criticism that the JT brand of casuistry cannot be aligned with the medieval version of casuistry because the former is not privy to the agreed-upon moral infrastructure (i.e., Christian doctrines) embraced by the latter:

> [The Critic] overestimates what is needed in order for casuistry to be a useful method of reasoning. Admittedly, *some* shared moral assumptions are necessary; specifically, agreement is needed concerning the ethical values held to be relevant to cases and concerning moral judgments for at least *some* paradigm cases. Agreement over paradigm cases need not hold for every case we attempt to resolve, but only *enough* for casuistry to be generally helpful. However, this *amount* of agreement seems to be possible despite the existence of contemporary moral pluralism. People from diverse moral communities *generally* acknowledge and accept the main ethical values of secular bioethics, such as beneficence, autonomy, honesty, fidelity, fairness, and so on.[40]

Strong's reply to the first objection is not as effective as he thinks, for the following reasons. First, Strong does not make clear the difference between (a) "some moral assumptions" and (b) "ethical values," and he slides from (a) to (b) as if they were identical. Moral assumptions are generally related to issues and ethical concepts concerning duty, consequences, intuitions, and sentiments. In contrast, ethical values (or what are called principles) are captured by what Strong lists above (namely, beneficence, autonomy, etc.). The point here is that Strong is conflating the level of moral theory with the level of principles. If it is the case that Strong makes this conflation, then he would be suggesting that JT take seriously the importance of moral concepts (e.g., duty, intuitions, consequences, etc.) that are thought to be deeply embedded in moral theories. As I

[39] *Ibid.*, 407. At this point in the discussion, it might be thought that there is no need to belabor the analysis, since Strong concedes that the fifth objection cannot be overcome by JT. Restated, why care about the status of the first four objections, when the fifth objection cannot be met by JT's version of casuistry? I think the answer is three-fold: First, by employing a principle of charity, it seems only fair to give JT's analysis a philosophical fighting chance. It may be the case that a few or even all of the objections could be overcome with the help of Strong's critical salvage efforts. Second, Strong goes on in his own analysis to offer a way to get around the fifth objection confronting JT's account, but first he must show that the other four objections can be thwarted. Yet, I hope to make clear that even if Strong's version of casuistry were to overcome objection five, it still would need to overcome the other four objections, which I will argue are not so easy to dismiss. Third, by laying out all of the objections and rejoinders, I hope to offer a few additional criticisms that further debilitate the JT approach. The force of these additional criticisms are felt only upon examining both JT's and Strong's arguments.

[40] C. Strong. *Supra* note 3: 405 (emphasis added).

indicated in my earlier discussion, however, this adherence to moral theory is precisely what JT want to avoid. I submit that this conflation of (a) and (b) by Strong undermines JT's brand of casuistry, rather than supports it.

It might, however, be thought that Strong is using (a) and (b) synonymously, and this would discredit my above criticism. Charitably, I will grant this point. Even granting Strong this point, however, does not save him from what I will call the "threshold problem." Strong claims that agreements in paradigm cases need hold only for "enough" cases in order to see that casuistry is effective. The problem is that "enough" is a very cryptic term. He does not bother to spell out exactly what he means by "enough." Let us assume that the practitioners of the medieval version of casuistry were able to generate 98 percent agreement on paradigm cases. The question would be: What percentage must the current brand of casuistry successfully achieve, relative to the medieval version, in order to make sense of "enough"? Is 50 percent or 90 percent enough? Unfortunately, Strong provides no answer.

Moreover, Strong does not make clear what he means by "most cases." Again, let us assume that the medieval version of casuistry is able to generate 100 percent agreement on paradigm cases in straightforward cases and 95 percent agreement over controversial cases. Putting aside for the moment the added difficulty of determining what criteria distinguish a straightforward case from a controversial case (e.g., diet cases vs abortion cases), what kind of percentages over these two classes of cases must the new casuistry achieve in order to be considered "enough"? Restated, what is the percentage threshold that constitutes "enough" and why is that percentage acceptable? The point is that much more needs to be said in terms of percentages and how those percentages range over the two classes of cases in order for this claim to be an effective reply to the first criticism. So, as it stands, Strong's attempt to save the first criticism is not successful because he does not address adequately the threshold problem.

Still, Strong could reply to this threshold problem by stipulating a fairly high percentage (e.g., 80 percent) and the corresponding empirical evidence (e.g., statistical evidence that shows agreement between doctors and patients) that constitutes "enough" and thus brush aside this problem as well. Again, I will concede this reply and offer what I take to be a rather damaging criticism that Strong cannot so easily evade. To the point, Strong gives the impression that agreement on ethical values will be easy to come by, which will in turn make paradigm cases easy to generate.

The above reply that Strong could make misses the point of the actual criticism in a few ways. First, the concern is not *primarily* whether or not casuistry is a useful method. The concern is that of justification and generation of moral values and paradigm cases. With regard to the medieval version of casuistry, conflict resolution had its origin ultimately in the authority of biblical interpretations provided by the religious figures of the day (e.g., the eating of meat offered to false idols by non-believers). These religious figures provided claims of the sort: "Values W and X are more relevant than values Y and Z because W and X reflect doctrines A and B of the Bible on our inter-

pretation of passages C and D of the Bible." Moreover, moral values could be further justified in relation to a specific eschatology—i.e., the potential survival of the soul into one of two realms, heaven or hell, based on one's doings in the earthly realm. It is this background—the idea of "meeting one's Maker"—that ultimately could be relied upon by medieval religious figures in justifying the adherence to a particular decision. It is the combination of (1) the affirmed authority of religious figures, (2) the word of God as put forth in the Bible, and (3) the consequences of not obeying the commands given by (1) and those "divine laws" in (2) that both generates and justifies particular moral judgments and paradigms about specific cases. The secular modern version of bioethical casuistry has no such infrastructure upon which to rely, due to the moral pluralism that permeates contemporary society. Thus, Strong's attempt to argue for a reasonable connection between medieval casuistry and contemporary casuistry is, at best, underdeveloped.

Assessment of Objection #2

The second objection is the claim that casuistry is not able to achieve consensus on all moral issues. Strong's reply to this objection is rather straightforward. He says that anyone who offers this criticism

> greatly over-estimates the ambitions of casuistry and. . . places unreasonable demands upon it. Casuists neither seek nor expect *society-wide consensus* concerning *all* conclusions reached by casuistic argumentation. Casuistry could be described as seeking conclusions that are hypothetical rather than categorical: they are reasonable if one accepts certain assumptions about ethical values and paradigm cases.[41]

To begin, Strong has misrepresented the JT version of casuistry. I take it that the possibilities are as follows with regard to the scope of casuistry:

A. If one accepts the tenets of the JT brand of casuistry, then it can help resolve *all* cases in medical settings.
B. If one accepts the tenets of the JT brand of casuistry, then it can help resolve *most* cases in medical settings.
C. It is possible to convince society as a whole, given all the details of any medical case, that a particular conclusion about a particular case is *most likely* the correct decision.
D. It is possible to convince society as a whole, given all the details of any medical case, that a particular conclusion about a particular case is *absolutely* the correct decision.

As I understand Strong's position, he thinks that either (A) or (B) is the correct way to understand the JT version of casuistry. Jonsen, however, is quite clear about the

[41] C. Strong. *Supra* note 3: 407 (emphasis added). This point is supported by Hunter, who explains, "This ingrained awareness of the potential variability of the individual case is also related to what philosophers on occasion have described as physicians' unwillingness–some have said their inability–to generalize about ethical issues. Pressed for a solution to a moral dilemma, a physician is likely to answer, 'It depends–'." *See* Hunter, Kathryn M. 1989. A science of individuals: medicine and casuistry. *The Journal of Medicine and Philosophy.* 14.2: 201-202.

scope of his version of casuistry.[42] The following three claims made by Jonsen are rather telling on this point:

1. "[T]he ordinary course of moral judgment—and I mean even the difficult cases that arise within settled practices and institutions—are resolved by casuistry rather than by recourse to theory."[43]
2. "The prudent person also appreciates the way in which certain actions, under certain circumstances, correspond to the ideals that he or she credits. In both the social and personal realm, prudent judgment apprehends the fit of maxims and circumstances."[44]
3. "Justification of any particular moral claim comes rarely from a single principle, as many theories would like, but usually from the convergence of many considerations, each partially persuasive but together convincing with plausible probability."[45]

Taken together, these three claims by Jonsen reveal that he thinks casuistry can handle the difficult cases in medical settings (better than traditional moral theories can), which the prudent person is able to determine by employing the appropriate maxims for both herself and society as a whole, and can come to a decision that is "convincing with plausible probability." If this interpretation of the JT thesis is correct, then I submit that it resembles interpretation (C) above. That is, JT do think that it is possible to convince society as a whole, given all the details of any medical case, that a particular conclusion about a particular case is *most likely* the correct decision. Contrary to Strong's interpretation, the JT version of casuistry should not be interpreted in the conditional sense of (A) or (B).

Now that we have an accurate account of the scope of the JT version of casuistry, we are in a position to see why the second original objection still holds. The second original objection is that we live in a society that is fragmented fundamentally with regard to the justifications that underlie controversial issues in the medical arena. Is it unjust that people not be given a basic level of medical care? Is it acceptable for a woman to do with her body as she wishes? No doubt, the plethora of religions, cultures, and secular viewpoints that coexist in the United States will result in diametrically opposed answers to these and other controversial questions. The possibility of "most likely" convincing religious fundamentalists, who make up a fairly large association in the United States, that abortion or euthanasia is sometimes acceptable does not at all appear to be an end that can be achieved by the JT casuistic method. For no discussion on paradigm cases can compete with "the word of God." As Arras articulates it: "Contrary to the assuranc-

[42] The reader should note that possibilities (A) and (B) concern the truth of the entire conditional—not merely the truth of the consequents.

[43] A. Jonsen. *Supra* note 13:246.

[44] A. Jonsen. *Supra* note 21: 304.

[45] A. Jonsen. *Supra* note 11:15.

es of Jonsen and Toulmin, the new casuistry is an unlikely instrument for generating consensus in a moral world fractured by conflicting values and intuitions."[46]

Assessment of Objection #3

The third objection to the JT version of casuistry is that it relies on a version of intuitionism in which moral judgments depend on a prudent person's own "moral insights" regarding what actions are either right or wrong. Strong replies to this criticism that "it fails to consider [Jonsen's] comments on the structure of moral argument in casuistry."[47] Unfortunately, Strong does not say much more about this point. In order to make sense of Strong's claim, I will recapitulate briefly my interpretation of Jonsen's views about the structure of moral argument in casuistry that I provided earlier.

Recall that moral reasoning in particular cases, according to Jonsen, would be as follows:

> I *judge* that person(s) V should or should not perform act(s) W *because* of reason(s) X, *unless* circumstance(s) Y bears on the case Z.

So, the Jehovah's Witness example provided earlier might be constructed as follows:

> I *qua* doctor judge that the refusal of blood transfusion treatments for the father of this family be honored *because* patient autonomy and the voluntary nature of the father's request must be respected, *unless* it is known that the father is the sole provider of his family.

The immediate question that comes to mind is "Why should one accept patient autonomy as an acceptable justification to let this patient die?" Moreover, if patient autonomy is the correct principle that governs this case, what justifies abandoning the patient's request when it comes to be known that he is the only "bread winner" in the family? Keep in mind that the concern here is an epistemic one—that is, how does the doctor *know* that reason(s) X and mitigating circumstance(s) Y are those that should be relied upon in this particular case? Although Jonsen does not directly address this case, he does give a general answer. He says:

> The prudent person has *the knack of recognizing* that following this or that maxim, in these or those circumstances, contributes to the support of strengthening of the relevant social institutions or that, contrariwise, certain actions will undermine or modify the institution in certain ways. . . The prudent person can be quite ordinary, but is marked by *'common sense'* joined to experience and linked to the ideals that makes [*sic*] possible good judgments. In addition [he] must be educated in the issues of his field. Such education consists, in great part, in knowing the cases. Knowing the cases means familiarity with the circumstances, maxims and arguments that make each case unique and, at the same time, make it fit into a taxonomy. If there is any sense in which [he] can rightly be called an expert, it is because [he] has *the knack of doing* this well and of showing others how to do it.[48]

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[46] J. Arras. *Supra* note 10:43.

[47] C. Strong. *Supra* note 3: 406.

[48] A. Jonsen. *Supra* note 21: 304 and 306. In another article, Jonsen similarly says: "Moral judgment is a patterned whole into which principles, values, circumstances must be fitted. The particular judgment

According to what Jonsen tells us in the above quotation, the prudent man has a knack for recognizing and doing the right thing in a particular case based on (1) "common sense," (2) relevant education, and (3) knowledge of cases. Relevant education is fairly clear. The prudent person *qua* doctor surely must have the requisite medical training and medical education in order both to determine the health status of her patients and to provide the appropriate medical care to her patients. Additionally, as part of the doctor's education, she must also have knowledge of the "issues" of her field, which includes the ability to fit correctly her current cases into the appropriate taxonomy of cases. This knowledge and ability to fit cases correctly, Jonsen tells us, is "learned from reflective experience" and "comes from the wisdom of experience."[49] "Common sense," given Jonsen's account, emerges as a result of wisdom and reflection based on experiences.

These are lofty expressions but they actually convey very little. To see this, let us return to the Jehovah's Witness case. Imagine that the doctor has had several Jehovah's Witness cases in the past. Given these past cases, one could argue that the doctor was able to determine that patient autonomy and the relevant family circumstances were essential in her reasoning. However, this does not really solve the epistemic concern. The problem is that the doctor had to make a decision concerning *the first* Jehovah's Witness case, where the patient waved off life-saving treatment, in which the doctor was not able to rely on any past experiences or cases that were similar to it. What was the justification of *that first decision* on the part of the doctor? Did it "fit" into a freedom of religion category? Did it fit into a case of patient autonomy? Was the psychological well-being of the patient called into question in that first case? Given the fragmented nature of society on moral issues, the doctor could not rely on what "society thinks is right." The point is that the doctor would have had to rely on *something* in order to determine the right decision. It seems, at first glance, that the doctor would have had to rely on her own *intuition* about what is the right thing to do in this first Jehovah's Witness case. More generally, every straightforward case and complex case will have a corresponding first case in which a doctor will not be able to rely on any past specific cases. In the end, the casuist has recourse only to her own intuitions so that the process of paradigm recognition and the development of "common sense" can get off the ground. Notice that Strong's reference to Jonsen's understanding of the structure of casuistic reasoning does not support the JT thesis against the charge of intuitionism. Thus, the objection of intuitionism still holds against JT's version of casuistry.

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itself must be fitted into a larger set of judgments about moral suitability of behavior and practices. Fittingness suggests how we 'morally appreciate' the circumstances of a case. Appreciation is, originally, an esthetic concept: we appreciate a painting, a landscape, a symphony, a good play, whether drama or a throw from shortstop to second to first. This sort of esthetic appreciation arises, in part, from the harmonious fitting together of various elements that may be, in themselves, heterogeneous. A moral judgment about a case is, I think, similar. Principles, values, circumstances, and consequences must be seen as a whole. The judgment about them comprises all of them." *See* A. Jonsen. *Supra* note 12:45.

[49] A. Jonsen. *Supra* note 21: 304-305.

Assessment of Objection #4

The fourth objection to JT's "new casuistry" is that alternative sets of paradigms can be chosen by medical practitioners and these sets of paradigms can result in conflicting conclusions about what to do in a given case. Strong's attempt to avert this criticism offered by Tomlinson[50] is as follows:

> The proper reply, I believe, is to express skepticism that there is such a problem. It is important to note that Tomlinson does not succeed in illustrating this supposed problem. [In a particular case] Tomlinson asks whether an alternative taxonomy is possible, involving a paradigm case of 'care of the patient,' rather than killing. However, Tomlinson does not actually put forward such a paradigm, much less show that using it would lead to a different solution.[51]

Rather than providing an actual criticism of the fourth objection, Strong's reply in the above passage could be interpreted as a challenge. The challenge could take the following form: If it can be shown that alternative sets of paradigms can be determined for a particular case and that these sets of paradigms lead to conflicting decisions, then Tomlinson's criticism will have been vindicated. I will take this challenge and confirm Tomlinson's worry.

I will employ one of Strong's own cases as part of my response to him. The case is as follows:

> An eight-day-old female infant was diagnosed as having erythroblastosis fetalis, or Rh disease. The conditions that cause this disease arise when fetal blood containing a specific antigen enters the bloodstream of a mother whose blood lacks that antigen. Maternal antibodies are then produced, and in subsequent pregnancies the antibodies cross the placenta and attack fetal blood cells that have the antigen. In this case, the infant was rapidly losing her red blood cells due to hemolysis caused by the antibodies. The physician informed the parents that the child needed blood transfusions to survive. However, the parents were Jehovah's Witnesses and refused to permit transfusions for the infant. Without transfusions, it was highly probable that the patient would die. In the unlikely event that she would survive without transfusions, she probably would have brain damage and mental retardation caused by hypoxia resulting from the low red blood cell count. Blood transfusions are effective in treating Rh disease and would likely result in the survival of a healthy child. For this type of case, the transfusion therapy itself has a risk of mortality estimated to be three deaths per 1000 cases.[52]

To begin, this case is fundamentally about whether or not care (i.e., blood transfusions) should be provided for this child. If blood transfusions are performed, then the chances are rather high that the child will develop in a healthy fashion. If blood transfusions are not performed, then the chances are high that the child will die or will suffer brain damage/retardation. There is one very important element missing from this description—an element that Strong himself omits. If the blood transfusion is *not*

[50] *See* T. Tomlinson's criticism. *Supra* note 37.
[51] C. Strong. *Supra* note 3: 406.
[52] *Ibid.*, 401.

performed, then not only is it the case that the child will die or suffer brain damage, *but*, according to a Jehovah's Witness, she will also have *a soul* that is completely pure. This second conjunct is crucial in order to describe the case as carefully as possible, an indispensable criterion for the casuist. What should the attending physician(s) do in this case? Let us turn to the JT approach in order to determine what to do.

I will not here provide all the details of the morphology of this case. Recall that morphology is the descriptive elements of a case that includes the "who, what, when, where, why, how, and by what means." Strong describes the case robustly enough so that the reader could easily determine these details.

I will now turn to Jonsen's criterion of taxonomy. To begin, we need to know the general taxonomy under which this case falls. A doctor could claim that this case fits under the paradigm case of *care of a patient*. The spectrum of cases can range from justified care of a patient to those cases of unjustified care of a patient. Within this spectrum, the well-being of a child versus parental authority is relevant, for parents do have some degree of authority over the lives of their children. Along the spectrum of cases that fit this general paradigm could be the punishment of children, the education of children, the health care of children, and so on. Given that medical treatment is the concern in this case, the health care of children would be the appropriate specific category from which to judge this case. Further, there is a spectrum of cases that range from justified parental intervention with regard to their child's health and unjustified parental intervention with regard to their child's health. This doctor could argue that given the potential harm that could befall the child as a result of omission of care, the well-being of the child is more important than the authority of the parents.

Furthermore, the doctor could argue, given Jonsen's account of kinetics—that is, the shift in moral judgment from paradigm cases to analogous cases based on perceived features of the particular case at hand—that the decision of the parents not to allow care for their child in this case is much like a very severe case of child neglect. The result is that this case is more on the unjustified-parental-intervention-with-regard-to-their-child's-health end of the spectrum. The doctor in this case could conclude that a court order forcing the parents to allow the transfusions to be performed is the correct decision. So, under the general classification of patient care and the much more specific paradigm of the health care of children, the blood transfusions should be given to the child. The results of this decision would be that the child would probably live without any major health problems and would live (in the eyes of a Jehovah's Witness) along with a damaged soul.

I will offer a plausible alternative interpretation of this case. Let us assume that the doctors have tried with all their might to persuade this couple to allow the transfusions to occur. Yet, in the end, the couple refuses to accept their medical advice, offering a detailed account of how their child's soul will be damaged from such medical care. Let us further assume that the child dies partially due to not receiving the blood transfusions (I say "partially" because causation is a complicated issue, given that both

proximate and distal causes play contributory roles in effects). The doctor involved in this case could claim that this is a case of justified killing. Let me explain. After a long discussion with the parents and upon much reflection about their beliefs, the doctor could claim that the correct paradigm case from which to judge this case is that of killing. Within the paradigm of killing, there is a spectrum that ranges from both justified killings to unjustified killings. More specifically, the spectrum ranges from the justified to the unjustified killings of infants. For example, at one end of the spectrum, it might be morally justifiable to kill an infant if it may save the lives of many other infants and, at the other end of the spectrum, it might be morally unjustifiable to kill an infant to spite one's morally bankrupt spouse. As I understand Jonsen's procedure, the trick is to figure out where this case fits along this particular spectrum.

Now, we have to include Jonsen's notion of kinetics. Within this spectrum of killings, it could be argued by the doctor involved in this case that the religious beliefs of the parents take precedence over any secular notions of harm. On this view, it is true that the parents will have allowed their child to die, but their justification is that the next life of the soul of their child will be blessed truly. On this interpretation, the allowing of one's child to die for the sake of one's child's soul is more on the justified side of the spectrum than on the unjustified side. (For the sake of this discussion, I will ignore the killing versus letting die distinction.) So, the added details of the religious beliefs of the parents has "moved" this case to a case of justified killing from that of unjustified killing. It follows, then, that under the general paradigm of killing, the correct decision is to abide by the wishes of the parents not to administer the blood transfusions and not to acquire a court order against the parents. The results of this decision are that the child will probably die or suffer severe brain damage and will be in possession of an uncontaminated soul.

To summarize what has transpired in this Jehovah's Witness case, I provided one scenario in which the correct decision is to proceed with the blood transfusions in order to save the life of the child. The justification for this decision is the result of a combination of the general paradigm case of patient care and the more specific case of excessive parental authority in the health of a child from which this case was judged. On the other hand, I provided another scenario in which the paradigm case was killing. Given the religious beliefs of the parents, I argued that this case was more along the lines of justified killing, specifically justified killing of an infant. I then concluded that the correct decision in this case is that the doctors should respect the wishes of the parents and that the child should not be given the blood transfusions.[53] The result of this

[53] Although he does not go in this direction, Strong could reply that Jehovah's Witness cases do not really pose a societal threat because such cases are really outlier scenarios. Thus, his defense of JT's casuistic approach need not have to reconcile such medically recondite scenarios. This is a reasonable rejoinder, but legal precedent, even in outlier cases, can have genuine mainstream implications. Consider, by analogy, the *Yoder* decision (*Wisconsin v. Yoder, et al.* 1975) that it is not compulsory for Amish communities to have their children publically educated beyond the eighth grade. As a result of this decision made in favor of an "outlier group," many religious groups have pursued legal recourse in order to seek religious exemptions from standard applicable law (*see* Shulman, Jeffrey. 2014. *The Constitutional Parent: Rights, Responsibilities,*

analysis is that I have met Strong's challenge and have vindicated Tomlinson's criticism that alternative sets of paradigms can generate alternative conflicting decisions on what to do in a given case through the use of the JT casuistic method.

Further Concerns

Before concluding this essay, I would like to provide two additional criticisms of JT's version of casuistry that have been overlooked in the literature to this point. Throughout this essay, I have avoided mentioning any of the major philosophical problems that are frequently debated by philosophers in the field of medical ethics. I am referring to debates surrounding the understanding of concepts such as "harm" or "pain," the debate about whether there is a meaningful distinction between "killing" and "letting die," or the concern over whether or not act-omission is a relevant feature of causation, and so on. The reason for the absence of an analysis of these issues in this essay is the result of the specific nature of Jonsen's subdivisions within his basic category of morphology. Specifically, it is the subcategory of *substructure* that I want to evaluate.

Recall that Jonsen thinks that there are "invariant patterns of discourse" within practical discourse (see morphology discussion, pp. 152-53). As Jonsen says, "Regardless of the specific content of the case (the circumstances), the forms of argument called topics [remain] invariant." For example, imagine a case where a doctor gives his (consenting and requesting) terminally ill patient a large dosage of morphine knowing full well that this amount will cause his patient to die (i.e., the doctor knows that respiratory suppression and then death of the patient will ensue as a result of the morphine injection). Is this a case of killing or letting die? Jonsen claims the following regarding the doctor's actions:

> Certain points must be covered in order to make the case for or against his moral accountability. Among these points, *intention is always relevant*. [In the above case], the [doctor's] intention, whether to kill or to assuage pain, must be reviewed, since he used a means, morphine, which will do both. Is he killing or merely helping her to be more comfortable and only allowing her to die? The casuists' distinction between direct and indirect killing was crafted for this situation. This distinction, and its larger formulation as the so called Principle of Double Effect, has fallen into disfavor with philosophers in recent years. However, that disfavor stems, I believe, from thinking of the distinction as *a principle* rather than as *a general topic*, an invariant form of argument that fits within any discourse about moral accountability and moral causality.[54]

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and the Enfranchisement of the Child. New Haven: Yale University Press and Johnson-Weiner, Karen. 2015. Old order Amish education: The Yoder decision in the 21st Century. *Journal of Amish and Plain Anabaptist Studies* 3.1: 25-44 for more on the legal and social implications—both within and outside of the Amish community—of this landmark decision). Thus, at the very least, it is not obvious that societal harm is not very likely with respect to Jehovah's Witness cases.

[54] A. Jonsen. *Supra* note 21:300 (emphasis added). For an excellent example of some of those philosophers who argue about the killing versus letting die distinction that Jonsen has in mind, *see* Steinbock, Bonnie and Alastair Norcross, eds. 1994. *Killing and Letting Die*. Second Edition. New York: Fordham University Press and Dworkin, Gerald, R. G. Frey, and Sissela Bok. 1998. *Euthanasia and Physician-Assisted Suicide*. Cambridge: Cambridge University Press.

Jonsen's remarks in the above passage are, at the very least, some cause for concern. I will mention two of those concerns, a primary and a secondary concern. The primary concern I have is that Jonsen appears to contradict himself when he stipulates that intention must always be taken into consideration when determining whether or not a doctor is or is not morally culpable for his actions *qua* doctor. It should be the case that nothing (or very little) should be accepted *a priori* by the JT-type casuist without first examining the particular case under consideration. For example, in a particular case of physician-assisted suicide, the most crucial factor in the case might be that *the consequences* of keeping the terminally ill patient alive or terminating the life of the terminally ill patient greatly outweighs taking seriously any other considerations, including the doctor's intentions. I am not insisting that such a case has actually come to be in the case of care for terminally ill patients. Nonetheless, it is a possibility that cannot be ruled out by the JT-type casuist—every case must be judged independently of any other case because nuances may arise in the particular case under investigation that may very well "morally move" the case in one direction or another. So, at the very least, there is an incongruity between Jonsen's claim that "[e]ach case is unique in its circumstances, yet similar in type to other cases and can therefore, be compared and contrasted"[55] and his insistence that certain moral concepts (e.g., intentionality) are always morally relevant.

A secondary concern I have is that closer scrutiny of Jonsen's distinction between (1) a principle and (2) a general topic could very well result in the kind of intractable problems he thought were faced by those who insist that a particular moral theory should guide decision-making in medical cases. Jonsen says that practical (medical) discourse has arguments that "have invariant patterns that can, and must be used, in any substantive argument."[56] What one would want to know is what constitutes an invariant feature such that one could decide that causation and intentionality are invariant features of all cases and belong in the subcategory of "general topic," while features X, Y, and Z are not invariant features of cases and belong in the category of "principle." If a more rigorous account of invariance is not provided, then one could insist that some feature(s) that one holds to be important should be included as an invariant feature. For example, the consequentialist could reply that not only are causation and intentionality invariant features of a case, but so are consequences.

If the above analysis is correct, then exactly the problems faced by those who espouse a particular moral theory will come to haunt the JT version of casuistry as well. For Jonsen now has to give an account of what invariant feature—e.g., intentionality or consequence—is the more important invariant feature in determining the moral culpability of a doctor's action(s) in a particular case. If, as Jonsen thinks, one would be unable to make a morally acceptable decision through the traditional top-down moral-theoretic approach, then one would have just as much difficulty in determining what the morally acceptable course of action would be under his system. Putting aside

[55] A. Jonsen. *Supra* note 13: 241.
[56] A. Jonsen. *Supra* note 21: 299.

any other difficulties with Jonsen's account, his principle/general topic distinction would leave him just as "paralyzed" as the moral theorist.

Final Remarks

In this essay, I provided an analysis of a version of "The New Casuistry" proffered by JT. After providing a brief historical backdrop and the details of the JT version of casuistry, I explicated five criticisms that, when taken together, seem to render this version of casuistry ineffectual in providing a strategy for decision-making in medical settings. Despite the apparent force of these criticisms, Strong offers what he takes to be a definitive reply to four of the five of these criticisms. His conclusion is that, for the most part, the JT brand of casuistry is a rather effective means of determining what to do in medical settings. My analysis, however, has revealed that Strong has not shown satisfactorily that the JT version of casuistry can withstand these four criticisms. Moreover, I offered two criticisms of my own which indicate that the JT brand of casuistry suffers from some of the same difficulties that JT think are deeply problematic with the traditional "top-down" moral-theoretic approach. Finally, let me say that I agree with JT and Strong that matters of life and death require much philosophical reflection. Moreover, there is little doubt that their efforts have revealed that cases in medical ethics cannot be trivialized given that human life hangs in the balance—the details of cases need to be presented in all their complexity. Although I do not think that JT's brand of casuistry can be reduced to Kant's "chit chat of everyday life," I maintain that it is not a serviceable procedure from which to determine what to do in medical settings in the light of such complexity.

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Teaching OB/GYN Residents Bioethics within a Catholic Healthcare Context

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ABSTRACT: Residents entering training in the specialty of Obstetrics and Gynecology (OB/GYN) often have misconceptions as to what medical interventions Roman Catholic healthcare institutions prohibit, and why certain restrictions are placed on the provision of reproductive health options that are otherwise legally available to women. The Ethical and Religious Directives for Catholic Healthcare Services, produced by the United States Conference of Catholic Bishops seeks to provide a stable framework upon which reproductive health decisions can be based. However, Catholic healthcare ethics may conflict with secular bioethical assertions that place a premium on autonomous patient choice. Residents training in part or whole at a Catholic institution may feel frustration at what they perceive to be a conflict with current secular ethics paradigms—such as access to abortion, contraception, sterilization, and assisted reproductive technologies. The recent adoption of Clinical Competencies by the Accreditation Council for Graduate Medical Education (ACGME), directs that residents shall be trained to function within the framework of their larger healthcare system ("Systems-based Practice"). This article will first, clarify areas of conflict and convergence between Catholic and secular reproductive ethics, which are unique to OB/GYN training. Next, using the ACGME's new Clinical Competency in Systems-Based practice as a model, a rationale for incorporating Catholic Healthcare ethics into an ethics curriculum for OB/GYN residents will be discussed. Finally, guidelines for faculty tackling the problem of how to teach Catholic Healthcare ethics will be described. Incorporating the

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rich tradition of Catholic healthcare ethics into the educational curriculum of OB/GYN residency fulfills training requirements while exposing young physicians to a rational decision-making framework in bioethics.

Bioethical issues arise out of conflict: whether conflict between provider and patient, patient and family, or patient and societal standards. Perhaps more than in any other medical specialty, the field of Obstetrics and Gynecology raises difficult bioethical questions that may result in conflict. While issues such as abortion and cutting-edge reproductive technology come readily to mind, the Obstetrician Gynecologist (OBGYN) also faces ethical dilemmas regarding end of life care in the field of Gynecologic Oncology.

Resident and medical student education in bioethics has focused primarily on the American College of Obstetricians and Gynecologists' (ACOG) recommendations. These broad, secular recommendations, by their very nature, do not address all the bioethical concerns when conflicts arise. Thus residents and students are left with a non-specific and often superficial framework for decision-making.

That Catholic healthcare is an integral part of the American healthcare scene is undeniable. Currently there are four medical schools associated with Jesuit Catholic educational institutions: St. Louis University, Loyola, Creighton, and Georgetown. Additionally, as of 2005, there were 615 Catholic hospitals in the United States, representing all 50 states.[1] Even if not trained at a Catholic institution, many OBGYN's will have the opportunity to work at a Catholic hospital during their career. Unfortunately, most will enter that relationship with only a superficial understanding of how and why Catholic healthcare ethics differs from ACOG's ethical positions. This fundamental lack of knowledge ultimately damages relationships between providers and institutions, and unfairly subjects Catholic institutions to derision. For instance, a recent and widely-cited campaign by the American Civil Liberties Union (ACLU), "Health Care Denied," attacked the role of the *Ethical and Religious Directives for Catholic Healthcare Services* (ERDS) in American Catholic hospitals while simultaneously noting the immense contribution of Catholic Healthcare in this country.[2] According the ACLU, "Because of these rules [the ERDS], many Catholic hospitals across this country are withholding emergency care from patients who are in the midst of a miscarriage or experiencing other pregnancy complications."[3] Unsupported statements such as these demonstrate the profound disconnect between many in society and the Catholic institutions that serve them.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) indentified six general competencies held to be of importance for physicians. These competencies were applicable across all medical and surgical specialties, and were

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[1] Catholic Information Project, US Conference of Catholic Bishops. http://www.nccbuscc.org/comm/cip.shtml#toc10 . Accessed 2010.

[2] Kaye, J. et al. *Health Care Denied*. The American Civil Liberties Union. New York. May 2016.

[3] Health Care Denied. The American Civil Liberties Union. https://www.aclu.org/feature/health-care-denied?redirect=healthcaredenied. Accessed 23 Mar 2017.

the basis for the evaluation of outcomes of a residency training program's stated goals. Thus, each program was required to evaluate how well its training prepared graduates in these six competencies: patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The latter states in part that residents are expected to "work effectively in various health care delivery settings and systems relevant to their clinical specialty," and, "coordinate patient care within the health care system relevant to their clinical specialty."[4] By failing to train residents in the ethical framework of healthcare delivery within Catholic hospitals, many graduate medical education programs in fact fall short of this requirement.

In Monty Python's "The Meaning of Life,"[5] one musical number contrasts a prolific Catholic family with their neighbors, abstentious protestants who are nonetheless free to use birth control. As the name suggests, the musical number, "Every Sperm is Sacred," parodies a common misunderstanding of Catholic doctrine on contraception. This misunderstanding isn't limited to secular British comedy troupes, however; a basic lack of knowledge of Church teaching is common among practicing Catholics.[6] It is even more mystifying for an evangelical protestant such as me, who enters practice in a Catholic University and hospital without prior exposure to such teachings. Given the role Catholic institutions play in healthcare delivery, it would be beneficial for all resident physicians to have some idea of what informs Catholic institutional ethics. I have tried to provide basic examples to introduce both residents and faculty discussion facilitators to principles in the ERDS, recognizing that there may be situations where neither faculty nor residents are familiar with the document.

ACOG's Approach

For years the ethical guidelines most readily available to OBGYN's for use in residency training have been ACOG's "Ethical Decision Making in Obstetrics and Gynecology."[7] While acknowledging a multiplicity of approaches to ethical dilemmas, ACOG emphasizes a fundamental basis of three "major" principles: autonomy, justice, and beneficence / nonmalfeasance. This approach provides the overarching framework taught to residents for ethical decision-making; however, the document recognizes that using these simple principles falls short of providing guidance when principles conflict. For example, when does patient autonomy trump the desire to "do no harm"; or, when does beneficence toward an individual trump the just rationing of health care to a group?

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[4] Common Program Requirements, Accreditation Council for Graduate Medical Education, Feb 2007.

[5] Goldstone, J. (Producer), Jones, T. & Gillia, T (Directors). 1983. *The Meaning of Life* [Motion Picture]. United States: Universal Pictures.

[6] Giroux, J. Catholic News Agency. *What is the Big Deal About Catholics Using Birth Control?* http://www.catholicnewsagency.com/cw/post.php?id=638. Accessed 23 Mar 2017.

[7] Committee on Ethics, American College of Obstetricians and Gynecologists. *Committee Opinion: Ethical Decision Making in Obstetrics and Gynecology.* Number 390, Dec 2007.

Catholic Healthcare Ethics

The theological underpinnings of Catholic healthcare ethics are based on Natural Law and Divine Law. For Catholics, Divine Law is based on the both the Old and New Testament as interpreted by the Magisterium of the Roman Catholic Church.[8] These were initially elucidated in the 1981 United States Conference of Catholic Bishops,' *Health and Healthcare: A Pastoral Letter of the American Catholic Bishops*.[9] They were subsequently codified into principles in the *Ethical and Religious Directives for Catholic Healthcare Services* (ERDs).[10] The ERDs are directed primarily at the provider, chaplain, and hospital staff member; and provide a clear framework on which to evaluate ethically relevant clinical issues.

Utilizing the ERDs allows the health care team to frame their ethics discussion and decision-making around several key concepts. When addressing any ethical issue, several questions can be answered. First, what are options and alternatives for the patient? How severe is her disease process, and will the interventions under discussion ameliorate loss of life, or merely impact quality of life? If the patient is adamantly seeking a healthcare option that directly conflicts with Catholic values and the ERDs can the patient find care at another institution? Asking these questions will help illuminate the often murky ethical dilemmas that can arise in the real world.

Modules for Teaching Residents and Students

The modules presented are created to provide an introduction to the topic of Catholic healthcare ethics and the ERDS. They are created to be administered by faculty without a prior understanding of the ERDS, including faculty of any faith or philosophical belief. Further, the modules are intended to be presented within an already-full didactic curriculum. Thus, not all important bioethical issues that intersect OBGYN can be addressed: as examples, embryo adoption, the care of families with prenatal anomalies, and gender reassignment.

The following modules are designed to stimulate discussion and to introduce the ERDs to residents. In creating them an attempt has been made to keep them as clinically uncomplicated as possible; at the same time, these modules represent potential real-life occurrences. These issues were chosen because they commonly conflict with ACOG's perspective on health care delivery. ACOG generally favors unrestricted access to abortion, contraception / sterilization and fertility treatments, with restrictions placed on individuals and entities rights of "conscientious refusal."[11] Comments under the discus-

[8] Boudinhon, A. (1910). Canon Law. In *The Catholic Encyclopedia*. New York: Robert Appleton Company. Retrieved from New Advent: http://www.newadvent.org/cathen/09056a.htm. Accessed 24 Mar 2017.

[9] United States Conference of Catholic Bishops, *Health and Health Care: A Pastoral Letter of the American Catholic Bishops*. Washington, DC: United States Conference of Catholic Bishops, 1981.

[10] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Healthcare Services* (Washington, DC: United States Conference of Catholic Bishops, 2009).

[11] Committee on Ethics, The American College of Obstetricians and Gynecologists. *Committee Opinion: The Limits of Conscientious Refusal in Reproductive Medicine*. Number 385. November 2007 (Reaffirmed 2016).

sion below represents the discussion leader's information that may be introduced after the residents / students have had an opportunity to speak openly about their solutions.

It would be helpful for the discussion leader to review the ERDs, which are widely available in print and electronic formats. During discussion, however, questions may arise that are not covered in the module. This would be a valuable time to introduce the topic of the institutional ethics committee. Far from being simply a rubber stamp for medical decisions or an impediment to be overcome, the institutional ethics committee can be an invaluable aid in wading through the sometimes complex issues involving healthcare ethics. Residents/students should be introduced to the concept of the hospital ethics committee, familiarized with the members of the committee, and given information on how to obtain an ethics consultation. Having a member of the ethics committee sit in on the modules is an invaluable way to build rapport.

Module 1, Abortion

Mrs. J is a 21 year old G2 P1 at 20 weeks gestation who presents to labor and delivery with spontaneous rupture of membranes 3 hours ago; this is confirmed on sterile speculum exam. Her antenatal course has been unremarkable and all laboratory tests have been normal; her pregnancy is dated by her last menstrual period and by an ultrasound at 10 weeks that confirmed her gestational age.

She reports no fevers, no chills or other systemic signs. Her cervix appears closed on speculum exam. She is not contracting, her white blood cell count is 10.1, and fetal heart tones are in the range of 150 beats per minute. Her vital signs are stable.

1. What management options would you consider and discuss with the patient? Please list at least two.

The participant should recognize that general medical care provides two options for this patient: either delivery or continuation of the pregnancy. Since the patient is pre-viable, induction of labor would inevitably result in the death of the baby. Most residents / students will recognize the Catholic position on abortion as stated in ERDS 45:

> Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

In this case, the mother is clinically stable. While there is concern about the development of infection with the patient's membranes ruptured, there is no evidence of infection at this time. Also, while the patient may have a higher likelihood of delivery with her membranes ruptured, there is a potential that medical therapies could prolong labor to the point of viability. As such, induction of labor would not be supported by the ERDS.

2. What clinical events would lead you to re-assess the patient's situation?

As noted above, evidence of intrauterine infection such as increasing abdominal pain, fevers, fetal heart rate abnormalities or purulent discharge would suggest chorioamnionitis. In which case, ERDS 47 states:

> Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

The concept of "proportionality" is extremely important in this case. When prolongation of the pregnancy is likely to result in the death of the mother (for instance, with chorioamnionitis where the patient could become septic), the ERDS permits delivery of the fetus. Obviously, the physician's input on the likelihood of death is critical. A morbidly obese pregnant woman may have more of an increased risk of death during pregnancy than a normal weight woman, but this does not mean per se she is *likely* to die during pregnancy.

Module 2, Birth Control

Mrs. S is a 26 year married old non-smoker, who is overweight. She is without other medical problems. She is interested in contraception. She has irregular menses which may occur between 21 and 48 days. After evaluation she is found to be oligo-ovulatory. She reports that she may be interested in pregnancy in the next year.

1. How would you counsel her on contraceptive options?

In assessing this patient, it's important to note that the patient has a number of options for birth control. It is also valuable to discuss their desire for future child bearing. In general, Catholic healthcare does not promote the use of contraceptive agents. According to directive 52, Catholic institutions are restricted from the use of contraceptive agents:

> Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.

Many individuals, whether or not they are members of the Catholic Church, do not understand the rationale for the Church's stand against contraception. According to the Papal Encyclical, *Humanae Vitae*, the use of contraception violates "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning."[12] Catholic reproductive health ethics does not allow the separation of human sexuality within the context of marriage from the generative potential of the act.

There are certain pastoral exceptions; some women may benefit from oral contraceptive pills to treat medical problems. Conditions such as profound menometro-

[12] Giroux, J., *supra* note 6.

rrhagia may be treated primarily with hormonal contraception without the intention of using them for birth control. Thus, there may be a "proportional benefit" for some women to use birth control pills though these pills may, as an indirect effect, have a contraceptive effect. Directive 33 states that:

> The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

Module 3, Infertility

Mr. and Mrs. P are a 35 year old couple, unsuccessfully attempting pregnancy for 3 years. They have undergone a full evaluation including a normal semen analysis, normal hysterosalpingogram, normal thyroid stimulating hormone and normal prolactin. In discussion with the couple they question whether in vitro fertilization may be an option, but report that they're not sure about it since they try to follow the teachings of the church.

1. How would you counsel the couple about IVF?

[This section was discussed in the module on contraception and may be skipped if covered in the same session]. Many individuals, whether or not they are members of the Catholic Church, do not understand the rationale for the Church's stand against contraception. According to the Papal Encyclical, *Humanae Vitae*,[13] the use of contraception violates "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning." Catholic reproductive health ethics does not allow the separation of human sexuality within the context of marriage from the generative potential of the act.

Fertilization of the ovum extracorporally violates this principle. IVF separates the unitive act of human sexuality from procreation. As such, Directive 41 states:

> Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).

2. What other options could you offer?

Directive 39 does permit the use of certain services for infertility:

> When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.

[13] Pope Paul VI, Encyclical Letter *On the Regulation of Birth* (*Humanae Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1968), no. 12.

Natural family planning affords a safe option for some patients. When more aggressive treatment is warranted, the use of medications to stimulate the production of gametes and to trigger ovulation is acceptable.

Module 4, Justice

An individual suffering from severe intellectual disability presents to your office for her first GYN exam at age 25, having been sent by the physician in charge of the group home in which she lives. It takes up a significant amount of time getting the patient into the exam room and undressed; unfortunately, it becomes clear that the patient is very resistant to undergoing a pelvic exam.

1. What options do you have?

Three options exist: to assess the situation as "too traumatic" for her and forego the exam, to press ahead and complete the exam despite the minimal patient cooperation, or to reschedule the exam to be done with sedation at a same day surgery unit.

Catholic healthcare places emphasis on the protection of the marginalized in society, recognizing the biblical concept that all persons bear the image of God and thus have intrinsic value regardless of their situation. While some would be tempted to proceed with the exam despite the patient's protestations, this would violate her autonomy. Directive 3 states that:

> In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination…. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

Close discussion with the patient's guardian is warranted to decide the relative benefit of performing a gynecologic exam under anesthesia. A prudent provider might also look for other opportunities to provide needed healthcare services to the patient while undergoing the exam: for instance, dental care might be performed concomitantly. Ultimately the patient and her guardian should be involved in the decision making, as Directive 27 makes clear:

> Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

Conclusion

There are a number of reasons why it is vital for residents and medical students to be introduced to Ethical and Religious Directives for Catholic Healthcare. First, many residents already work within an institution affiliated with the Roman Catholic Church. As a rule, physicians in training benefit from standardization and guidelines. It is difficult for them to have to arrange care for their patients while functioning in a system

that they do not understand. Second, those same physicians may eventually go on to practice in a Catholic institution. At that point, knowledge of the boundaries in which they practice will go far toward alleviating frustration. Third, from a very pragmatic standpoint the RRC has mandated a "systems-based" approach to resident education. So far no resources are generally available integrating the ERDs into the educational curriculum and this project fills a much-needed space in national resources.

The information has been directed toward OB/GYN residents but it may be utilized with minimal modification with medical students. It may be necessary to emphasize certain important clinical points—such as the understanding in module 1 that the mother with ruptured amniotic membranes is not immediately in distress.

Euthanasia in Belgium: Legal, Historical and Political Review

Toni C. Saad, M.A.*

ABSTRACT: This article describes and evaluates the Belgian euthanasia experience by considering its practice and policy, both before and after the formal decriminalisation of euthanasia in 2002. The pre-legal practice of euthanasia, the evolution of euthanasia legislation, criticism of this legislation, the influence of politics, and later changes to the 2002 Act on Euthanasia are discussed, as well as the subject of euthanasia of minors and the matter of organ procurement. It is argued that the Belgian euthanasia experience is characterised by political expedition, and that the 2002 Act and its later amendments suffer from practical and conceptual flaws. Illegal euthanasia practices remain a live concern in Belgium, something which nations who are seeking to decriminalise euthanasia should consider.
Keywords: **Belgium, euthanasia, medical ethics, physician-assisted suicide**

In 2002 Belgium became the second nation in the world to legislatively decriminalise euthanasia,[1] with the Netherlands preceding it by mere months.[2] The Belgian euthanasia experience (BEE), which began before euthanasia was formally decriminalised, and its legal, historical, and political context, is the subject of this article. It aims to provide a broad overview of the law and its evolution, and elucidate the uniquely rapid and politically-motivated development of the BEE from its pre-legal origins to its most recent developments, in five main sections.

The first is a survey of euthanasia practices before formal decriminalisation in 2002. The second sets the scene for the passing of the 2002 *Act on Euthanasia* by considering the political forces which influenced its coming into law. The third is a detailed discus-

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[1] Physician-assisted suicide, however, was decriminalised in Australia and Oregon, USA, in 1996 and 1997 respectively. *See* Gorsuch NM, 2006, *The Future of Assisted Suicide and Euthanasia*. Princeton University Press. Pp. 2-7.

[2] Euthanasia was *de facto* legalised in the Netherlands long before this date following a court ruling in concerning the 1973 "Postma case." *See* Gevers S in *British Medical Bulletin*. 1996;22: pp. 326-33.

sion of the 2002 *Act on Euthanasia*, including a summary of criticisms that have been levelled against it. The fourth, more briefly, will survey the state of euthanasia practices after the passing of the 2002 *Act* which connects to the fifth section's discussion of later amendments to the *Act* and the subject of the relationship between euthanasia and organ procurement. The overall aim is to describe, contextualise and evaluate euthanasia as it has developed in Belgium, both in practice and in policy.

Defining Terms

The Belgian *Act on Euthanasia* defines euthanasia as follows: "for the purposes of this Act, euthanasia is defined as intentionally terminating life by someone other than the person concerned, at the latter's request."[3] Thus, in Belgium, euthanasia is only such if it involves a request from the person receiving it. This definition of euthanasia is somewhat idiosyncratic; it more accurately signifies what is usually called "voluntary euthanasia," because euthanasia *per se* does not necessarily involve consent.[4] This definition is not unique, however. It is lifted almost *verbatim* from what has been called the "odd Dutch definition,"[5] which Dutch definition was the one unanimously assumed in the consultation processes which preceded Belgium's decriminalisation of euthanasia.[6] Hence, from now on, "euthanasia" will be used here in the *Act*'s sense of the word, unless preceded by modifiers.

I. Euthanasia Before Its Decriminalisation

One of Belgium's particularities is that euthanasia was relatively common and well-documented while it remained illegal. Two studies in the *Lancet* have recorded this phenomenon. In the first, Deliens *et al.* (2001) surveyed physicians in Flanders concerning their end-of-life decisions. As a result, they estimated that there were:

- 705 deaths due to euthanasia and physician-assisted suicide (PAS) (equivalent to 1.3% of total deaths);
- 1,796 deaths due to lethal prescriptions without patient consent (3.2% of deaths);
- 3,261 deaths due to the withholding of treatment with the explicit intention to hasten death (5.8% of deaths).

This is clear evidence that illegal end-of-life practices in Belgium were fairly common, with at least 4.5% of deaths having been achieved illegally.[7]

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[3] This quotation, along with all other direct quotations from the Act is taken from "Belgium (Euthanasia)" (2003) *European Journal of Health Law*, 10(3), pp. 329–335, a translation of the Act.

[4] J Law (ed.), *A Dictionary of Law* (Oxford University Press: Oxford, 8th ed., 2015) p. 240.

[5] J Finnis, *Human rights and common good: Collected essays* volume III. (Oxford University Press: United Kingdom, 2011) p. 253.

[6] E Vermeersch, "The Belgian law on Euthanasia the historical and ethical background" [2002] *Acta Chirurgica Belgica,* 102(6), pp. 394.

[7] L Deliens, F Mortier, J Bilsen, M Cosyns, RV Stichele, J Vanoverloop and K Ingels, "End-of-life decisions in medical practice in Flanders, Belgium: A nationwide survey" (2000) *The Lancet*, 356(9244), pp. 1806–1811.

The second study drew on data pertaining to nearly 3,000 Belgian deaths up to February 2002. Its authors found that 1.82% of these deaths were due to PAS, voluntary and non-voluntary euthanasia. This last category accounted for 1.5% of the deaths.[8]

Therefore, euthanasia and other illegal end-of-life practices were prevalent before the formal decriminalisation of euthanasia in 2002. Moreover, before 2001 there were "no or hardly any cases of persecution [sic], let alone punishment, of any physicians that have performed euthanasia."[9] Not only was illegal euthanasia occurring, but it was not being followed up in the Courts either. This is why there is no Belgian case law concerning euthanasia (much in contrast to the Dutch euthanasia laws, which largely codified pre-existing case law.[10])

Hence, Belgium found itself in 2002 in the peculiar situation of decriminalising something which some members of the medical profession already engaged in with impunity. There was clearly little desire to report acts of euthanasia, and little willingness on the part of the authorities for legal prosecution. It could be, therefore, that Belgium's *ex post facto* legislation was simply a natural development in the practice of euthanasia; it has rightly been said that "as moral feeling recedes so too does the desire to convict or to subject to punishment."[11]

As well as in the surprising lack of prosecution of euthanasia, this public sentiment can be seen in the formation of pro-euthanasia societies. In 1983 the *Association Belge pour le Droit de Mourir dans la Dignité*[12] was founded, and followed in the same year by its Flemish analogue *Vereniging voor het Recht op Waardig Sterven*.[13,14] Both these organisations remain active. Additionally, some pro-euthanasia physicians have gained ascendancy through the Belgian media, notably Professor Wim Distelmans who has reportedly euthanized hundreds of patients, and has become something of a popular euthanasia guru.[15,16]

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[8] A van der Heide, L Deliens, K Faisst,T Nilstun, M Norup, E Paci, G van der Wal and PJ van der Maas "End-of-life decision-making in six European countries: Descriptive study" (2003) *The Lancet*, 362(9381), pp. 345–350.

[9] B Broeckaert, "Belgium: Towards a legal recognition of Euthanasia" (2001) *European Journal of Health Law*, 8(2), pp. 95.

[10] M Adams, "Comparative reflections on the Belgian Euthanasia act 2002" (2003) *Medical Law Review*, 11(3), pp. 353–354.

[11] R Scruton, *The Meaning of Conservatism*. (St Augustine's Press: South Bend, Indiana, 3rd ed., 2002) p. 72.

[12] Belgian Association for the Right to die with Dignity. Today they offer doctors and patients practical and theoretical advice about end of life decisions. *See* http://www.admd.be/Moyens_Action.html [Accessed 04 August 2016].

[13] Association for the Right to Die with Dignity. They too remain active today, offering legal and practical advice, support as well as guidance concerning living will. *See* http://www.rws.be/web/over-rws/ [Accessed 04 August 2016].

[14] Vermeersch, *op. cit*., pp. 394–397.

[15] Distelmans also chairs the Federal Control and Evaluation Commission which reviews and audits all reported cases of euthanasia. *See infra*.

[16] R Aviv, "The Death Treatment" (2015) *The New Yorker* (22 June).

More tangibly, between 1984 and 1996, nine euthanasia bills were submitted before the Belgian Parliament.[17] These bills were minimally influential in regard to changing statute because of various political factors (see later discussion), but they demonstrate the positive political disposition towards euthanasia, and anchored the issue of euthanasia in public awareness.

This growing acceptance of euthanasia is part of a Europe-wide change in attitude. Out of twelve European countries surveyed for views on euthanasia between 1981 and 1999: "a significant increase in acceptance of euthanasia…can be observed in almost all countries. The average increase was 22%. The average was especially high in Belgium (69%)."[18] The authors of this study also note that Belgium's changing attitude to the subject was rapid as well as large, and coincided with an even faster and greater decline in religiosity.[19] The BEE therefore, rather than being anomalous, is perhaps one of the first materialisations of changing moral sentiment.

All this shows that the passing of the *Act* can scarcely be considered surprising. That a change in the law should be called for is only natural if the practical-moral principle from which the law is derived is no longer respected. The law serves as useful deterrent to those who are not persuaded by practical reasons relating to the common good, but if general indifference in regard to these principles sets in, the law loses its force and instructiveness.[20] Hence the BEE is only an aftershock of deeper and more distal architectonic changes in morality. Nevertheless, the detail of the development of the BEE bears consideration for the purposes of this paper.

The Development of Decriminalisation

The evolution of the euthanasia laws began in the mid-1990s. In 1996, after euthanasia bills had previously been submitted by four different members of parliament, the Federal Advisory Committee on Bioethics (FACB)[21] was founded.[22] It is a multidisciplinary group composed of 70 members, whose remit is strictly advisory and non-partisan.[23] It does not make recommendations, but merely lays out options reflective of popular opinion.[24] Its first assignment, set by the chairmen of the Senate and the House of Representatives, was to advise parliament concerning the desirability of decriminalising or legalising euthanasia.[25]

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[17] Broeckaert. *op. cit.*, pp. 95–107.

[18] J Cohen, I Marcoux, J Bilsen, P Deboosere, G van der Wal and L Deliens, "Trends in acceptance of euthanasia among the general public in 12 European countries (1981-1999)" (2006) *The European Journal of Public Health*, 16(6), pp. 663–669.

[19] *Ibid.*, p. 667.

[20] J Finnis (1980) *Natural Law and Natural Rights*. Chapter 10.

[21] Also known as the Belgian Advisory Committee on Bioethics (BACB).

[22] T Meulenbergs, and P Schotsmans , "Law-making, ethics and hastiness: the debate on euthanasia in Belgium" (2002) *Ethical Perspectives* 9(2-3):86.

[23] Vermeersch *op. cit.*, p. 394.

[24] Meulenbergs and Schotsmans *op. cit.*, pp. 86-87.

[25] *Ibid.*, p.86.

Despite the FACB's intentional diversity, it unanimously agreed on: the "Dutch" definition of euthanasia; that it therefore follows that euthanasia is decriminalised for conscious and competent patients only; that ceasing futile treatment is not euthanasia, and that the term "passive euthanasia" is therefore undesirable; and that death which is not intended but foreseen should be distinguished from euthanasia.[26] Based on this shared starting point, the FACB went on to provide a spread of options and opinions. These were given in two reports.

The first, *Report No. 1 of the FACB concerning the Desirability of Legislation on Euthanasia*, was published in May 1997. It put forward four options: first, that euthanasia be recognised as a patient right, and thus be legalised; second, that euthanasia be decriminalised if the physician is able to demonstrate *a posteriori* that he acted with due diligence; third, that euthanasia be decriminalised if proper *a priori* consultation takes place and due diligence can be demonstrated; or, fourth, that euthanasia remain prohibited by law.[27] It has been said of the third proposal: "…the discussion of the third proposal has created a rapprochement between several proponents and opponents of a legal prohibition of euthanasia. This explains why this proposal received much attention and inquiry during a long time."[28] While the FACB stopped short of recommending the legalisation of euthanasia, it "did hold that it [euthanasia] can be justified in some circumstances."[29]

Though the FACB acknowledged that it was neither competent nor obliged to resolve the debate about euthanasia, and admitted that its members were divided,[30] its first report is perhaps an indication of a generally positive or indifferent sentiment towards euthanasia. Notwithstanding, the report ends with a point of unanimity: "the complete Committee demands a large democratic debate on this topic between all directly involved and, on a larger scale, among all citizens."[31] As will become apparent, such a call was not met.

Report No. 1 was presented to the Belgian Senate in December 1997, on the first of two days of debate on euthanasia. All parties, including the Christian Democrats,[32] appeared willing to participate in the discussion. It was decided that the discussion should continue in a different forum, the Joint Senate Commission of Justice and Social Affairs. A second report from the FACB was also anticipated, which would eventually be delivered in late February 1999.[33]

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[26] Vermeersch, *op. cit.*, p. 394.

[27] H Nys, Advice of the Federal Advisory Committee on Bioethics concerning legalisation of euthanasia (1997) *Eur J Health Law*, 390-392.

[28] *Ibid.*, p. 392

[29] P Schotsmans and B Broeckaert, "Debating Euthanasia in Belgium: Part Two" (1999) *Hastings Centre Report* 29. 5. p. 48.

[30] Nys, *op. cit.*, p. 393.

[31] *Ibid.*, p. 393.

[32] But excluding the Vlaams Blok, Belgium's far-right party who once enjoyed substantial public support.

[33] Broeckaert, *op. cit.*, p. 97.

In the meantime, the euthanasia debate advanced little. It has been suggested that this is due to concurrent parliamentary discussions concerning police and judiciary reform, and because some parties had not yet reached an internal consensus (or were perhaps awaiting the FACB's second report).[34] Two socialist parliamentarians[35] broke the deadlock by submitting a new euthanasia bill to parliament in early February 1999. In response, a few weeks later, the FACB published its second report on euthanasia.

Report No. 9 of the FACB concerning the Termination of Life of Incompetent Patients moved beyond the considerations of *Report No. 1* which accounted "only [for] requests coming from competent patients."[36] *Report No. 9* outlined three options: first, that the active termination of the life of incompetent patients in a hopeless situation should be legal, depending on the opinion of a second physician and consultation of advanced directives or patient's representatives; second, that such action should be made legal in certain special cases if it can be justified before the fact including by thorough medical examination, consultation of nurses, and ethical assessment, but not without the existence of an advance directive; third, that the law should continue to prohibit this.[37,38] This second report on euthanasia would turn out to be of limited influence due to co-existent political factors.[39]

Curiously, these reports, parliamentary debates, and the private members' bill of February 1999 influenced the end-of-life decisions made by doctors. Between 1998 and 2001 in Flanders, researchers noted a reduced incidence of euthanasia and non-voluntary euthanasia, and an increase in palliative care and involvement of family members and nursing teams.[40] Of this they say: "these shifts can, at least partly, be explained by social developments, closely related to the euthanasia legalization process."[41]

It is perhaps unsurprising that conduct should change in the run-up to a major change in the law. Illegal end-of-life practices were refrained from perhaps out of fear of prosecution in the wake of increased public awareness of the matter. Indeed, in 2000, for the first time in Belgium's history, the Public Prosecutor began to investigate the actions of two physicians accused of administering a lethal dose of drugs to a patient at his request. These doctors were not prosecuted because, by the time the judge ruled on the case in 2003, the charge was no longer a criminal offence[42]: the 2002 *Act* would

[34] *Ibid.*, p. 97.

[35] Lallemand and Erdman.

[36] Nys, *op. cit*. p. 389.

[37] Meulenbergs, and Schotsmans, *op. cit*. p. 89.

[38] Broeckaert, *op. cit*. p. 98.

[39] It is perhaps curious that *Report No. 9* should consider the termination of incompetent patients, because even bringing up the subject seems to lend tacit support to practice of euthanasia. It seems odd to discuss this subject before euthanasia is decriminalised. However, it could be that it was considered important to discuss it in order to inform the drafting of a first euthanasia law.

[40] J Bilsen, R Vander Stichele, B Broeckaert, F Mortier and L Deliens, "Changes in medical end-of-life practices during the legalization process of euthanasia in Belgium" (2007) *Social Science & Medicine*, 65(4), pp. 803–808.

[41] *Ibid.*, p. 807.

[42] Adams, *op. cit.*, pp. 353–354.

thus work *ex post facto*, and thereby exonerate all previous transgressions of the penal code with regard to acts of euthanasia. What is more surprising, however, is the speed at which the 2002 *Act* was brought into law, and the great influence political forces had on the process.

Political Influences[43]

A major catalyst of the rapid change in the law was the general election of June 1999, which resulted in the formation of a six-party coalition composed of Liberal, Socialist and Green parties,[44] and headed by the Flemish Liberal leader Guy Verhofstadt.[45] The Christian Democrats were conspicuously absent from this new government: after more than forty years in power they had suffered an historic defeat in the 1999 elections. Some attribute the accelerated process of decriminalising euthanasia to this fact: previously, Christian Democrats had expressed concern regarding euthanasia bills, and the chairman of the party had registered his strong opposition to it.[46] It would soon become evident that many within the new government desired the rapid legalisation of euthanasia.

One commentator says: "the ink of the coalition agreement was still wet when the first euthanasia bills were submitted."[47] The bill previously submitted in February 1999 was resubmitted by two different socialist parliamentarians in July 1999. Just a week later, a French-speaking liberal parliamentarian resubmitted his 1995 bill. Two other old bills were resubmitted in September and October 1999 respectively. Finally, even the French-speaking and Dutch-speaking Christian democrats submitted their own bills.[48] With this flurry of political activity, the decriminalisation of euthanasia seemed increasingly imminent.

Politicians were falling all over themselves to agree on this matter. Despite the differences between the bills submitted from the coalition parties, it was as early as December 1999 that a range of senators[49] jointly proposed three bills: *Bill Concerning Euthanasia*, *Bill Concerning the Establishment of a Federal Evaluation Commission with*

[43] The word "political" is used in two ways here: firstly, in a procedural sense, to refer to the actions and plans of politicians; secondly, to imply a certain political agenda, specifically a liberal one. This latter point is mentioned here to avoid falling into the trap which Mark Brown describes: "Although few commentators specify exactly what they mean by this claim, most echo the longstanding practice of calling something "political" whenever it becomes subject to partisan competition. Saying that an issue has become political is usually an all-purpose way of decrying corruption, hypocrisy, and narrow self-interest" (2009:43). Brown, M.B. (2009) "Three ways to politicize Bioethics," *American Journal of Bioethics*, 9(2), pp. 43–54.

[44] This is a "purple coalition" of social democrats which excludes the Christian democrats. It is called purple because of the mixture of red and blue colours of the coalition parties.

[45] British Broadcasting Company [1999] *New Belgian government sworn in*. Available at: http://news.bbc.co.uk/1/hi/world/europe/391670.stm (Accessed: 15 June 2016).

[46] Broeckaert, *op. cit*. p. 99.

[47] *Ibid.*, p. 99.

[48] *Ibid.*, p. 99.

[49] Mahoux, Leduc, Monfils, Vanlergerghe, Nagy, and DeRoeck.

Regard to the Application of the Law Concerning Euthanasia, and *Bill Concerning Palliative Care*.[50] In brief, these senators proposed decriminalising euthanasia, including in cases of psychological suffering, and for non-terminally ill patients.[51] The content of these bills was controversial, and some of it underwent change as a result of public consultation. We will explore these changes and the factors which stifled them. Beforehand, however, the true role of the Christian Democrats is worth considering.

Influence of the Christian Democrats

The reduced presence and influence of the Christian Democrats after June 1999 coincided with a quick succession of pro-euthanasia bills, and the passing of the 2002 *Act on Euthanasia* just a few years later. Just how influential was their absence in this connection?

Arguably, their presence in government would probably not have prevented its legalisation altogether, for they were not content to merely oppose the bills coming from coalition politicians, but submitted some of their own. Though these were less radical (they did not advocate the depenalisation of euthanasia, but merely ensured legal security for doctors who perform euthanasia in a state of necessity) they cannot be said to be entirely different from the bills submitted by coalition politicians.[52] Hence, Christian Democrats advocated, with caution, some sort of euthanasia legislation, meaning it is incorrect to attribute the passing of a euthanasia bill in Belgium merely to their diminished influence.

It is probably true, however, that their absence somewhat accelerated the decriminalisation of euthanasia, but that they also helped temper the content of the law.[53] The more significant factor to the decriminalisation of euthanasia is the change in *zeitgeist*, which should be distinguished from the change in the make-up of government.[54]

The political debate

The coalition/majority bill submitted in December 1999 was not voted on in the Senate in February 2001 as had been intended, because of much opposition to its contents. As a result, the Joint Commission for Justice and Social Affairs organised a series of hearings in which a cross-section of witnesses were interviewed; it then became clear that the bill as it stood was inappropriate, in the sense that it was concerning to many members of the public.

In November 2000, the majority bill was submitted in a slightly modified form. Its basic principle, however, remained unchanged. Discussion and debate followed over the course of which over 600 amendments to the bill were submitted, largely by the

[50] *Ibid.*, p. 100.

[51] Meulenbergs and Schotsmans, *op. cit.*, p.90.

[52] Broeckaert, *op. cit.*, pp. 99-100.

[53] Vermeersch, *op. cit.*, p. 395.

[54] Though it is, of course, impossible to separate these two things completely, for the make-up of a democratic government reflects wider social feeling; indeed, this is perhaps never truer than for a country like Belgium whose citizens are obliged by law to vote.

minority of Christian Democrat senators. In early March 2001, the Joint Commission accepted the amended bill.[55] In May 2002, the bill received a positive vote from the House of Representatives, and in October from the Senate. The amended euthanasia bill thus passed into law.[56] Belgium was the second country in the world, after the Netherlands,[57] to take this step.[58]

Some of its important safeguards include: expanding the role of the physician in evaluating the state and request of the patient; a stricter procedure concerning patients who are not terminally ill; a stipulation that the nursing team be consulted; and that the deaths be reported to the Federal Control and Evaluation Commission instead of the Public Prosecutor.[59] However, one serious shortcoming is the absence of a requirement for *a priori* consultation, something which the FACB had considered in its *Report No. 1*.[60]

Apart from these, the most significant difference between the original majority bill and the amended bill is the absence in the latter of a clause removing euthanasia from the penal code. Suggestion of the opposite had "aroused unanimously negative reactions. Even those who were in favour of a radical euthanasia legislation reacted negatively to the senators' initiative to amend the penal code."[61] However, it has been argued that this compromise, not mirrored in the Dutch law, was merely for the sake of expediency: changing the penal code would have taken longer than overlooking it, and would have been unpopular enough to halt the progress of any euthanasia bill.[62] Consistency is set aside for convenience. It might be that the penal code is changed in due course, but the current situation seems quite irregular. Additionally, unlike in the Netherlands,[63] minors are excluded from the *Act*, since doing otherwise was considered undesirably time-consuming.[64]

Though the Belgian government engaged in external consultation on the subject of euthanasia, it did so over a much shorter period of time than did the Netherlands. Additionally, bodies representing Belgian physicians were scarcely involved in the proceedings. In fact, some had campaigned and recommended against the decriminalisation of euthanasia. It is therefore very difficult to argue that it was the medical profession who initiated the change in policy[65]—Belgian doctors even expressed anger about their lack of involvement.[66] That said, some doctors were practising euthanasia anyway, and

[55] Broeckaert, *op. cit.*, pp. 101-103.

[56] Meulenbergs, and Schotsmans, *op. cit.*, p. 91.

[57] Dutch law came into force in April 2002.

[58] Adams, *op. cit.*, p. 354.

[59] Broeckaert, *op. cit.*, p. 102.

[60] Meulenbergs, and Schotsmans, *op. cit.*, p. 93.

[61] Meulenbergs, and Schotsmans, *op. cit.*, p. 90.

[62] Adams, *op. cit.*, p. 360.

[63] Though minors are euthanized according to Groningen Protocol.

[64] Adams, *op. cit.*, p. 362. Child euthanasia became legal in Belgium in 2014 (see later discussion on this subject).

[65] Adams, *op. cit.*, p. 373.

[66] *See* T Sheldon, "Belgium considers legalising euthanasia" (2000) *British Medical Journal*, 320, p. 137; Smets *et al*. 2011: "Although physicians had little involvement in the process of legalizing euthanasia, they now generally endorse the euthanasia law."

it might be that underlying unease about this impelled the political process. Regardless, the desire for the change in the law, rather than being evenly shared by the medical profession, the general public and politicians (as it was in the Netherlands), in Belgium, came largely from the chambers of parliament.[67]

With this historical context in place, we now turn to a detailed study of the law itself and consider its later developments, additions and amendments.

II. The Belgian Act on Euthanasia of 2002

In comparison to its Dutch equivalent of April 2002, the Belgian *Act* contains numerous and detailed stipulations. It is divided into six chapters.[68] Chapter I sets out the all-important definition of euthanasia which is taken to be, following the Netherlands, "intentionally terminating the life by someone other than the person concerned, at the latter's request."[69]

Chapter II lists the conditions under which euthanasia is legally performed. Section 3§1 exculpates those who commit euthanasia if: the patient is over 18 or an emancipated minor and is legally competent to make the decision to be euthanized; their request is "well-considered, repeated" and not the result of coercion; and the patient is in a "medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident." Section 3§2 outlines what the physician must do before carrying out an act of euthanasia. He must:

- inform the patient of their condition and discuss therapeutic and palliative courses with the patient and his relatives—indeed the act specifies that "together with the patient, the physician must come to the belief that there is no reasonable alternative to the patient's situation and that the patient's request is completely voluntary";
- achieve certainty regarding the patient's state by having "several conversations with the patient spread out over a reasonable period of time";
- consult another physician who must concur with the first's diagnosis;
- consult the nursing team if they have regular contact with the patient;
- discuss the request for euthanasia with the patient's relatives if the patient desires it;
- and ensure that the patient has had the opportunity to discuss their decision with persons they wanted to.[70]

Section 3§3 provides for those who request euthanasia but are not expected to die imminently. For these patients, an independent physician (a psychiatrist or specialist

[67] The particular composition of the government some of whose members so readily suggested euthanasia laws is significant, though it does not explain why politicians desired to do this in the first place.

[68] *See* note 1. All quotes from the Act are drawn from the translation cited in Footnote 1. *Op. cit.*, pp.329-335.

[69] *Ibid.*, p. 329.

[70] *Ibid.*, pp. 329-330.

in the relevant condition) must believe that the request is well-considered and that the patient suffers unbearably, mentally or physically. Secondly, at least one month must be allowed between the patient's initial request in writing and the completion of the act. To this end, 3§4 lays out how the request is to be made: it must be made in writing, and signed by the patient. It also considers those who cannot do this for themselves. Additionally, the request can be revoked at any time. Section 3§5 states that all these proceedings and consultations must be recorded in the patient's notes.[71]

Chapter III lays out the rules concerning the advance directive (AD). In brief, the law allows legally competent persons to make an AD to request euthanasia. The physician may follow this AD if the patient suffers a serious and incurable disorder, and is no longer conscious. The AD names trusted persons who are to inform the physician of its existence. The AD itself must be in writing and witnessed by two people, at least one of whom does not have a material interest in the patient's death. The patient may also designate someone to draft the advance directive for them if they are unable to do so themselves. Importantly, the AD is only valid "if it is drafted or confirmed no more than five years prior to the person's loss of the ability to express his/her wishes."[72]

Chapters IV and V consider how acts of euthanasia are to be notified to the authorities. Here the Federal Control and Evaluation Commission is established in law. Section V.6§2 prescribes the composition of this group: it is to be made up of senior physicians, lawyers and those who have dealings with people who are terminally ill; language parity is respected; and members serve a four-year term after appointment by the King on the recommendation of the council of ministers. Section V.7 details the information which must be recorded whenever an act of euthanasia is performed. Section V.8 explains that these forms will be checked by the commission, who will determine the legality of the act. The commission votes as to whether it considers to the *Act* to have been adequately adhered to. If a two-thirds majority considers it not to be lawful according to the *Act*, the case is to be handed over to the public prosecutor of the relevant jurisdiction. Section V.9 enshrines in law an audit of euthanasia by decreeing that statistical reports be made every two years.[73] It is interesting to note that a study found that only half of cases of euthanasia are reported to this group.[74]

Finally, Chapter VI considers special provisions. It states that "no physician may be compelled to perform euthanasia" and that "no other person may be compelled to assist in performing euthanasia." The clause allows conscientiously objecting physicians to opt out of performing euthanasia, while obliging them to explain their reasons to

[71] *Ibid.*, pp. 329-330.

[72] *Ibid.*, pp. 331-332.

[73] *Ibid.*, pp. 332-335.

[74] T Smets, J Bilsen, J Cohen, ML Rurup, F Mortier and L Deliens "Reporting of euthanasia in medical practice in Flanders, Belgium: Cross sectional analysis of reported and unreported cases" [2010] *BMJ*, 341, pp. c5174–c5174.

the patient for doing so.[75] The *Act* also adds: "if the refusal is based on medical reasons, then reasons are noted in the patient's medical record."[76]

Analysis of the Act

The Belgian *Act* does not permit assisted suicide. Some ask: "why regulate the 'greater' [euthanasia] but not the 'lesser' [assisted suicide]?"[77] The evidence laid out above suggests that this was most likely a political decision: making assisted suicide legal would have prolonged the parliamentary deliberations, which seemed undesirable.[78] It might also be that the *Act*'s silence on physician-assisted suicide is due to the way the phrase "assisted suicide" became distorted in parliamentary debate. In the minds of many it meant "simply killing someone at their request with no additional conditions," and, therefore, the Bill's proponents "did not want to be accused of supporting something so 'frivolous.'"[79] Nevertheless, there appears to be a conceptual lacuna at this point in the legislation.[80] It seems odd to pass legislation so reliant on a misunderstood definition. It would perhaps have been more reasonable to take the time to define terms appropriately, and thereby provide a good reason for distinguishing between physician assisted suicide and euthanasia (if a material distinction exists), rather than doing so on relatively trivial grounds.[81] The result is that the distinction might easily be repealed by a future amendment to the law, something which must considered a live possibility in view of the Act's evolution (see later section).

As in Dutch law, the *Act* does not stipulate that the physician performing the act of euthanasia be any sort of specialist (palliative or otherwise). However, unlike in the Netherlands where it is assumed *extra legis* that it is the attending physician who is to perform euthanasia (though this often not the case in practice), the Belgian law is silent on the matter. This opens the door to "travelling euthanasia doctors" who have also been

[75] These reasons need only be recorded in writing in the patient's notes if they are based on "medical reasons," however (VI.14).

[76] Act on Euthanasia, *op. cit*., p. 335.

[77] Adams, *op. cit.*, p. 356.

[78] It has also been pointed out that another reason for such a decision, both in the case of Belgium and other jurisdictions such as Quebec, might be that it frames euthanasia as medical procedure, and therefore as something appropriate to the physician, whereas suicide cannot be given such a gloss. *See* Margaret Sommerville, *Bird on an Ethics Wire,* pp. 149-151.

[79] Adams, *op cit.*, p. 357.

[80] Another possible interpretation of this is that by excluding PAS, the legislation becomes more palatable and therefore easier to pass. And this could be coupled with the knowledge that, in practical terms, it is very unlikely that a doctor would be prosecuted for PAS when euthanasia, "the greater," is already decriminalised.

[81] It is not obvious that a material moral distinction exists between euthanasia and physician-assisted suicide because the goal of each, the end to which actions are ordered, is the same: the intentional death of a patient at the hands of a private person. There are also practical reasons why the two are not so different: what of the patient who cannot swallow a lethal medicine, or press a button to release it, etc.? *See* Gorsuch, *op. cit*., p. 6. Clearly, if Oregon and Australia can legislate for physician-assisted suicide only, while Belgium can do so only for euthanasia, the reasons for this discrepancy are probably legal and instrumental rather than fundamental and moral.

a cause for concern in the Netherlands.[82] What is concerning about this is that these doctors are invested by the law with the power to choose between life and death for a patient whom they might have had no dealings at all until the momentous instant of euthanasia, which severs and corrupts the patient-doctor relationship.

A noteworthy difference between the Dutch and Belgian acts is the notable absence in the latter of reference to the nature of the offence committed if the *Act* is not adhered to. This is because, as already mentioned, the *Act* leaves the penal code unaltered.[83] Additionally, the *Act* fails to distinguish between degrees of severity of its violation, which raises questions about how different transgressions of the law are to be punished.[84] Therefore, it is unclear what is a serious breach of the *Act*, and how these should be prosecuted. Under what law will a doctor be prosecuted for failing to report an act of euthanasia? Will acts of euthanasia without consent be prosecuted under the *Act* or under the penal code? These questions and many others are left unanswered by the *Act*.

The way the Commission operates has also been criticised: Francis Pakes considers that

> in composition and procedure [it] has more of a feel of a 'Euthanasia High Court'. Its heavy composition, the anonymous review and also the procedures for the nomination and appointment of members gives the impression of awareness that this Committee will play a pivotal role in developing legal and medical practice in relation to life-ending behaviours.[85]

This is said because the way the committee operates is to consider the conduct of physicians holistically, not merely to tick the right legal boxes. This along with the expert panel makes the Commission comparable to a court of law, and thus gives it a degree of influence over public policy, for better or for worse, which its members might not have otherwise have had. This setup attracts criticism because the Commission's legal rationale for existence is to determine "whether the euthanasia was performed in accordance with the conditions and the procedure stipulated in the Act" (V.8); it might then be said that, in practice, the Commission risks overreaching its basis in law. This is a natural result of the ambiguities regarding prosecution described in the previous paragraph. Since it is unclear what constitutes a violation of the Act, and the Commission functions as an overall moral arbiter rather than as an objective observer of compliance with the law, it is to be expected that latitude with respect to law-breaking and interpretation will become part of the BEE. It is perhaps one of the more remarkable characteristics of the BEE that the area of enforcement and prosecution in relation to offences should be so reliant on interpretation and the tendentious notion of a holistic judgment.

A further omission of the *Act* is its exclusion of competent minors (in comparison to its Dutch analogue which provides for children as young as 12). Adams *et al.* posit that

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[82] Adams, *op. cit.* pp. 353-358.

[83] Adams, *op. cit.* pp. 359-360.

[84] Adams, *op. cit.* pp. 2003:360.

[85] F Pakes, "The legalisation of euthanasia and assisted suicide: A tale of two scenarios" (2005) *International Journal of the Sociology of Law*, 33(2), pp. 71–84.

doing otherwise would have been so controversial as to jeopardise the *Act*'s passing.[86] In hindsight, the omission could have been part of a cynical strategy to lay the foundations of a broader euthanasia law by starting with relatively palatable, thin-end-of-the-wedge legislation. A little over a decade after the *Act* was passed, it was amended to expand euthanasia to minors, with no lower age restriction.[87]

Finally, there is the phrasing of Chapter II Section 3§2: "together with the patient, the physician must come to the belief that there is no reasonable alternative to the patient's situation…". This emotive statement makes a stark assumption: in some situations there is no reasonable alternative to euthanasia—the implication being that any alternative is unreasonable (perhaps merely religious or superstitious?). The "no reasonable alternative" phrase can be interpreted in diverse ways. It is quite possible to argue that there do in fact exist reasonable alternatives to euthanasia, *e.g.,* palliative medicine, and the suggestion that choosing against euthanasia can sometimes be unreasonable is hard to sustain, and fails to take into account the radically different sets of values with which people approach euthanasia. Many people, unlike the authors of the *Act*, do not presuppose that it is one legitimate option among others, but that it is wrong or forbidden. Hence, the "no reasonable alternative" phrase is surely too prone to differing interpretation to be useful legislation.

From the analysis of the law and its evolution so far it can be concluded that Belgium's *Act on Euthanasia* suffers practical and conceptual problems in a patterned fashion. The practical problems seem to stem from the hasty nature of the process of legislation, whereby a relatively palatable bill was rushed into law with the possible ulterior motive of incrementally amending it after this is accomplished. The conceptual problems stem, it would seem, from what can be described as a sense of passivity in respect to the momentous decision to end a patient's life. One might expect the law surrounding such a decision to be explicit with regard to prosecution and offences, and that the systems in place for its enforcement would operate rather strictly, if only to avoid scandal. Yet such is not the case in Belgium. Why this is so is a question of philosophy and politics; it is beyond our remit. But it seems likely that some significant change has taken place in the Belgian public consciousness for them to tolerate this state of affairs. One can conjecture that such a parlous situation would be cause for a great scandal in the United Kingdom or Unites States of America.

III. Euthanasia Post-Legislation

Disregard for the Law

Since the 2002 *Act*, the development of euthanasia in Belgium has been studied closely. As cited above, it has been found that only half of all cases of euthanasia in Flanders up to 2007 were reported. The most important reason (76.7%) for not reporting

[86] M Adams, *op. cit.*, p. 362.

[87] L Bovens, "Child euthanasia: Should we just not talk about it?" (2015) *Journal of Medical Ethics*, 41(8), p. 630.

a case to the review committee "was that the physician did not perceive the act to be euthanasia." Furthermore, "a large majority of the unreported cases (92.2%) were in fact acts of euthanasia… but were not perceived or labelled as euthanasia by the physician involved."[88] Thus the *Act*, which stipulates that deaths must be reported to the Federal Control and Evaluation Commission (IV.5), is ignored. Thousands of deaths due to euthanasia were not being reported.[89] Similarly, a smaller interview study found that physicians were not practising euthanasia according to the *Act*, especially *viz*. its procedural requirements such as consulting a second physician.[90]

A study of patients who died between June and November 2007 in Flanders estimated that euthanasia and assisted suicide account for 2% of deaths. It also found that, of the 208 deaths involving life-ending drugs reported, 66 were without explicit request.[91,92] This suggests that significant numbers of illegal acts of non-voluntary euthanasia have taken place. Furthermore, among the 142 deaths which were preceded by consent, five of these were brought about by physician-assisted suicide, an illegal practice in Belgium.[93] Another significant legal infraction is the fact if nurses' administration of the lethal prescriptions, something which the *Act* states may only be done by a physician.[94]

Statistical trends

In accordance with Section V.9, the Commission publishes biennial reports into the implementation of the *Act*. The most recent of these is that of 2014, which considers data from 2012-2013.[95] It shows that euthanasia has increased by 89% in four years, from 953 reported in 2010 to 1,807 in 2013. Approximately four fifths of deaths due to euthanasia are from the Dutch-speaking Flanders region.[96]

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[88] T Smets, J Bilsen, J Cohen, ML Rurup, F Mortier and L Deliens "Reporting of euthanasia in medical practice in Flanders, Belgium: Cross sectional analysis of reported and unreported cases" (2010) *BMJ*, 341, pp. c5174–c5174.

[89] The study states: "the estimated total number of cases of euthanasia in Flanders in 2007 [is] of 1,040 …The incidence of euthanasia in Flanders in 2007 was thus estimated as 1.9% of all deaths."

[90] T Smets, J Bilsen, L Van den Block, J Cohen, V Van Casteren, and L Deliens, "Euthanasia in patients dying at home in Belgium: Interview study on adherence to legal safeguards" (2010) *British Journal of General Practice*, 60(573), pp. 163–170.

[91] K Chambaere, J Bilsen, J Cohen, BD Onwuteaka-Philipsen, F Mortier and L Deliens, "Physician-assisted deaths under the euthanasia law in Belgium: A population-based survey" (2010) *Canadian Medical Association Journal*, 182(9), p. 895.

[92] Among these deaths without patient consent, only about a fifth involved some prior discussion with the patient about the decision. *Ibid*., p. 896.

[93] *Ibid*., p. 896.

[94] R Cohen-Almagor, "First do no harm: Pressing concerns regarding euthanasia in Belgium" (2013) *International Journal of Law and Psychiatry,* 36(5-6), pp. 515–521.

[95] *Commission Fédérale de Contrôle et d'Evaluation de l'Euthanasie* [Federal comission for the control and monitoring of euthanasia] (2014) *Sixième Rapport aux Chambres Légisatives* [sixth report to the legislature]. Available at: http://organesdeconcertation.sante.belgique.be/fr/documents/cfcee-rapport-euthanasie-2014 (Accessed: 22 June 2016).

[96] European Institute of Bioethics, "Belgian Euthanasia increases by 89% in four years" (2015). Available at: http://www.ieb-eib.org/en/document/belgian-euthanasia-increases-by-89-in-four-years-382.html (Accessed: 22 June 2016).

A study which looked at rates of euthanasia between 2002 and 2007 found a year-on-year increase in that time period too.[97] These authors found a similar discrepancy between Flanders and Wallonia (83.3% of the 1,917 reported euthanasia cases for Flanders compared to 16.7% for Wallonia).[98] In accordance with other studies,[99] elderly patients are underrepresented, and young, male, and cancer patients are over-represented.[100]

These statistics illustrate at least two things. Firstly, that euthanasia rates are not abating; they appear to be rapidly rising year-on-year.[101] Secondly, there is cause for concern because of possibly very large numbers of unreported deaths by euthanasia, instances of failure to abide by the safeguards of the *Act*, instances of physician-assisted suicide, and even cases of non-voluntary euthanasia. These last two are a continuation of the precedent set by non-prosecution before 2002. At best, then, euthanasia is accelerating without complete government oversight and without adequate engagement from the medical profession. At worst, it could be argued that medical murder is taking place, and the situation is out of hand.[102] Hundreds of lives have been taken unlawfully. It is alarming that this can occur without public outcry or government crackdown. Doctors are, quite literally, as far as concerns the law, getting away with murder. The BEE, from the widespread existence of illegal euthanasia before its decriminalisation, to the politicking which led to its legislation, and its subsequent lack of enforcement, would be deeply embarrassing if it were not so tragic. Furthermore, concerns raised by this analysis will not be allayed by more recent developments in the BEE.

IV. Later Developments in the Law

The 2002 *Act*, due to the hastiness with which it was drawn up, has undergone several changes over the years.

The law and pharmacists

The first amendment to the 2002 *Act* came in November 2005. It decriminalised the act whereby a pharmacist dispenses a lethal prescription, provided the doctor assures him that he has duly followed procedure.[103,104] This amendment is intended to

[97] T Smets, J Bilsen, J Cohen, ML Rurup and L Deliens, "Legal Euthanasia in Belgium" (2010) *Medical Care*, 48(2), p. 187.

[98] *Ibid*. p. 188.

[99] T Smets, J Bilsen, J Cohen, ML Rurup, F Mortier, and L Deliens, "Reporting of euthanasia in medical practice in Flanders, Belgium: Cross sectional analysis of reported and unreported cases" (2010) *BMJ*, 341(Oct05 2), pp. c5174–c5174.

[100] Smets *et al*. 2010a, *op. cit.* p. 189.

[101] It could be that this is because rates of reporting are improving, though, as has been noted, rates of reporting remain low.

[102] LJ Materstvedt and M Magelssen "Medical murder in Belgium and the Netherlands" (2016) *Journal of Medical Ethics,* pp. medethics–2015–103128.

[103] H Nys, "Recent developments in health law in Belgium" (2006) *European Journal of Health Law*, 13(2), pp. 95–99.

[104] C Meek, "Pharmacy involvement where assisted suicide and euthanasia are permitted" (2006) *The Pharmaceutical Journal*, 277, pp. 614–619.

minimise the liability of pharmacists who participate in euthanasia and, at least in theory, guarantees that pharmacies stock such lethal drugs.[105]

Concurrent trends in Belgian bioethics policy

Though this last amendment is relatively minor, it is one of many changes in health laws which have recently been passed in Belgium. Nys, having listed several such new laws and amendments, states that they are all "from bills introduced in Parliament by members of Parliament and not by the Government itself."[106] This includes the 2002 *Act on Euthanasia*. These private members' bills, as opposed to bills introduced by the government, are not subject to the same degree of rigorous analysis such as the approval of the Council of State. Hence, they are more likely to be of poor quality, and more likely to require amendment.[107] Furthermore, Nys accuses the Belgian government of positively encouraging such bills in the area of bioethics.[108] He concludes: "One wonders why the lack of quality that would rightly not be tolerated in the field of, say, fiscal law or company law, is tolerated and even stimulated in the field of health law."[109]

This underlines the fact the BEE did not occur in a vacuum: it is but one visible development within a wider changing moral and legal scene.

Child Euthanasia

The second, more publicised, amendment came in 2014, and did away with the *Act*'s age restriction. Previously, the law stipulated in II.3§1 that recipients of euthanasia should have attained the age of majority (which is 18 in Belgium).[110]

On 28 February 2014, the amendment to the 2002 *Act* became statute, having previously been voted on 13 February by 86 votes to 44 (with 12 abstentions).[111] The amendment changes the wording of II.3§1, stating that euthanasia is not a criminal offence if the physician ensures that: "the patient has attained the age of majority or is an emancipated minor, who is competent or is still a minor who is capable of judgment, and is conscious at the time of making the request."[112]

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[105] Nys 2006, *op. cit*., p. 96.

[106] *Ibid*., p. 96.

[107] *Ibid*., p. 96

[108] *Ibid*., p. 96.

[109] *Ibid*., pp. 96-97.

[110] B Dan, C Fonteyne and SC de Cléty, "Self-requested euthanasia for children in Belgium" (2014) *The Lancet*, 383(9918), pp. 671–672.

[111] BBC, *Belgium's parliament votes through child euthanasia* (2014). Available at: http://www.bbc.co.uk/news/world-europe-26181615 (Accessed: 23 June 2016).

[112] "*…le patient est majeur ou mineur émancipé, capable ou encore mineur doté de la capacité de discernement et est conscient au moment de sa demande*." Translations are the author's own of: Service Public Fédéral Justice, '*Loi modifiant la loi du 28 mai 2002 relative à l'euthanasie, en vue d'étendre l'euthanasie aux mineurs*' [Law modifying the law of 28 May 2002 relating to euthanasia, with a view to extend euthanasia to minors] (2014). Available at: http://www.etaamb.be/fr/loi-du-28-fevrier-2014_n2014009093.html (Accessed: 23 June 2016).

The same section of the 2002 *Act* is further amended to add a fourth stipulation. For euthanasia to be legal, as well as satisfying the three previous provisions, the doctor must ensure that:

> the patient who is a minor who is capable of judgment finds himself in a hopeless medical situation of constant and unbearable physical suffering which cannot be alleviated and that will shortly lead to death, and is caused by an accident or by a serious and incurable pathology.[113]

The final substantial change comes in II.3§2 where a seventh provision stipulates that for euthanasia to be legal for a minor he or she should be examined by a child psychiatrist or psychologist.

Though it would seem that the general public has been largely supportive of this change in the law, it has divided the medical profession: a petition calling for the postponing of the parliamentary decision was signed by 170 paediatricians.[114] Additionally, the *Institut Européen de Bioéthique* (European Institute of Bioethics) issued a report which casts a dim light on the political procedure from which this amendment arose. They argue that the Chamber of Representatives did not engage in adequate reflection on the subject, having received the draft bill from the Senate only a few weeks before, thus not leaving enough time to amend it as necessary.[115] In other words, the origin of the bill is entirely in the Senate, whose ability to legislate on these matters has been questioned. Furthermore, the process of political consultation was not undertaken as it should: even though this was not emergency legislation, it was not submitted to the Council of State for advice, and several later suggested amendments were ignored. There was no obvious call for this bill in the first place, and, as with the 2002 *Act*, physicians were not consulted. The whole process was initiated and controlled by politicians who ignored expert advice and took juridical shortcuts. The report comes to this damning conclusion:

> the world first in extending euthanasia to minors without age restriction was hurried in, and is best explained by the fact that certain parties favoured purely political interest over a more carefully thought-through consideration of the interests of the main stakeholders: minors, their parents, and the medical profession.[116]

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[113] *Ibid*. "*…le patient mineur doté de la capacité de discernement se trouve dans une situation médicale sans issue de souffrance physique constante et insupportable qui ne peut être apaisée et qui entraîne le décès à brève échéance, et qui résulte d'une affection accidentelle ou pathologique grave et incurable…*"

[114] R Watson, "Belgium Extends Euthanasia to Children" (2014) *BMJ* 2014;348:g1633.

[115] JP Van De Walle, *Dossier de l'Institut Européen de Bioéthique: L'euthanasie des mineurs en Belgique* [Report of the European Institute of Bioethics: euthanasia of minors in Belgium](2015). Available at: www.ieb-eib.org/fr/pdf/20150302-euthanasie-des-enfants.pdf (Accessed: 30 June 2016) p. 2.

[116] European Institute of Bioethics, *Belgian Euthanasia increases by 89% in four years*. (2015). Available at: http://www.ieb-eib.org/en/document/belgian-euthanasia-increases-by-89-in-four-years-382.html (Accessed: 22 June 2016) p. 3. ["*La première mondiale de l'extension de l'euthanasie aux mineurs sans condition d'âge a donc vu le jour à la hâte, et s'explique largement par le fait que d'aucuns firent prévaloir des intérêts de type purement politique sur une prise en compte posée et réfléchie de l'intérêt des principaux concernés : les mineurs, leurs parents, et le corps médical*."]

In summary, the extension of euthanasia to children is largely politically and pragmatically motivated, rather than being based in a tradition of legal reasoning or serious consultation with interested parties.

Indeed, it wasn't until September 2016 that news broke of the first reported case of euthanasia of a minor. Few details have been reported so far, and these only in mainstream media outlets. It would seem the person in question was a "critically ill" 17-year old. Wim Distelmans released this information and added that few children are considered for euthanasia, but that those who are should not be denied access to it.[117] It does seem, therefore, that there is only minimal demand for euthanasia of minors, which raises the question of the relevance of the 2014 amendment. Moreover, even some of those who opposed this amendment admitted that they would be willing to grant minors' euthanasia requests anyway in some cases brought before ethics committees, even stating, tellingly, "do you really think that people care about is or is not stated in the law? [sic]."[118] One is left thinking that legislating the euthanasia of minors is merely a political gesture.

It remains to consider one final aspect of euthanasia which has been a cause for concern in some quarters.

Organ Procurement

Belgium has an "opt-out" organ donation system whereby explicit consent is not necessary to procure organs from the deceased.[119] Additionally, organ donation is on the increase in Belgium.[120] A study found that between 2005 and 2007, only four patients who underwent euthanasia also expressed a wish to donate their organs: they were aged between 43 and 50 and suffered from intractable neurodegenerative conditions.[121] In each case, protocol was rigorously followed to ensure the separation between the acts of euthanasia and donation, so that there could be no grounds to accuse the former of being motivated by the latter.

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[117] D Chazan, "Terminally ill child becomes first euthanised minor in Belgium" (2016) *The Telegraph*. [Accessed 26 Nov 2016] http://www.telegraph.co.uk/news/2016/09/17/terminally-ill-child-becomes-first-euthanised-minor-in-belgium/

[118] Marleen Renard quoted *ibid*., p. 632.

[119] J Bollen, R ten Hoopen, D Ysebaert, W van Mook and E van Heurn "Legal and ethical aspects of organ donation after euthanasia in Belgium and the Netherlands" (2016) *Journal of Medical Ethics*, pp. medethics–2015–102898.2-3.

[120] B Desschans and P Evrard "Organ donation and transplantation statistics in Belgium for 2012 and 2013" (2014) *Transplantation Proceedings*, 46(9), p. 3124.

[121] D Ysebaert, G Van Beeumen, K De Greef, JP Squifflet, O Detry, A De Roover, M Delbouille, W Van Donink, G Roeyen, T Chapelle, J Bosmans, D Van Raemdonck, ME Faymonville, S Laureys, M Lamy and P Cras, P, "Organ procurement after Euthanasia: Belgian experience" (2009) *Transplantation Proceedings* 41(2), pp. 585-586. Though four cases of organ donation post-euthanasia seems to be relatively few, to know this for certain would require a point of comparison. Such a thing is difficult to determine because people are very infrequently in a position where their death is imminent despite their body being in good enough condition to permit organ procurement. See subsequent discussion.

More recently, the Belgian Transplantation Society and Belgian Transplantation Council has promoted an updated definition of donation after circulatory death (DCD) to include a fifth category not previously part of the Maastricht classification: controlled DCD by euthanasia, known as DCD-V, *i.e.,* medically assisted cardio-circulatory death in hospital.[122] By this definition, organ donation after euthanasia would be permissible under Belgian law. This will not, however, necessarily generate a very large number of organs for transplantation because most patients requesting euthanasia have cancer, a contraindication for transplantation.[123] All the same, as we discuss below, this fifth category could be problematic.

Concerning lung transplantation, recent research shows that, between January 2007 and October 2015, euthanasia donors accounted for 12% of lung transplants after DCD, which represents 10/85 DCD cases, or 2% of total isolated lung transplants (10/511).[124] This has been a cause for alarm to some. Yet, it is difficult to compare like with like in this situation, because the circumstances of DCD-V are very different from those surrounding the other categories of DCD. For example, on the scale of all deaths, since euthanasia accounts for approximately 2% of total death, the 2% contribution DCD-V appears proportional.[125] But this conclusion does not consider the fact that many deceased people are ineligible to donate organs after their death, either because they choose to opt out or because of medical contraindications. In which case, it might be considered better to compare the euthanasia transplants with all the DCD transplants: euthanasia makes up 10 of the 85 cases of these, or about 12%. But, here, the problem of classification of DCD arises: the circumstances surrounding DCD-V are so unlike those of DCD categories I-IV that it is scarcely comparable. Not only is there the opportunity to exercise greater control/choice over death than might be possible in other DCD, but it also involves people of younger age than average life expectancy.[126] If about 88% of DCD is not post-euthanasia, then it might seem that they are not overly-represented. But this would assume that all DCD categories are comparable, which they are not. So euthanasia cannot rightly be compared to other DCD because of its strong element of choice and control. Indeed, even if DCD-V numbers exceeded the total number of DCD I to IV, which would mean that more people were choosing euthanasia than were afflicted by other categories of circularity death, it would not necessarily be a cause for concern because one can foresee circumstances where there are very few patients with CD who are eligible for donation. This makes evaluating such figures difficult.

Here is another example of this problem: Cohen-Almagor expresses his concerns about organ transplantation and euthanasia: "the fact that euthanasia donors accounted

[122] P Evrard, "Belgian modified classification of Maastricht for donors after circulatory death" (2014) *Transplantation Proceedings* 46(9), p. 3139.

[123] *Ibid*., p. 3412.

[124] D Van Raemdonck, A Neyrinck, S Van Cromphaut, S Verleden, B Vanaudenaerde, D Claes,K Degezelle, et al. "Transplantation of lungs recovered from donors after Euthanasia results in excellent long-term outcome" (2016) *The Journal of Heart and Lung Transplantation* 35(4), pp. S364-365.

[125] Chambaere, *op. cit*., p. 895.

[126] Van Raemdonck, *op. cit*.

for almost a quarter of lung donors while euthanasia cases accounted of 0.49% of deaths (in 2007[127]) should not go unnoticed."[128] This comparison is provocative, though perhaps misleading, for euthanasia deaths are not comparable to ordinary deaths. Hence it should be asked of those deaths which are not euthanasia: how many of those were viable donors who had not expressed a desire to opt out? It would be a fairer comparison to compare "viable" non-euthanasia deaths with "viable" euthanasia deaths, for even many euthanasia deaths are not compatible with organ transplantation due to medical contraindication.

So, though one is left with the feeling that something is perhaps amiss with the situation these statistics seek to illustrate, caution is required in their interpretation. Perhaps the only firm conclusion which can be drawn from them, is that it was unwise to make euthanasia part of the DCD category system, at least for the sake of comparison in cases such as this one.

Now, if a large majority of euthanasia patients were undergoing DCD, this might suggest a conspiracy. There is no conclusive evidence to establish this claim. Yet, it would be naïve to fail to see the convenient relationship between those healthy donors requesting euthanasia and the great need for organs; there is undoubtedly a temptation and opportunity for exploitation and coercion. If this is already taking place, it cannot be determined from the available statistics alone, however. The keynote until determinative statistical evidence emerges should be to discuss the risk of coercion in these cases; the patients involved, and the necessity of their making an informed and free choice, rather than any statistical comparison, should be the primary concern.

Conclusion

The 2002 *Act on Euthanasia* was a hasty and flawed piece of legislation which served to justify pre-existent practice. In a sense, it was a mere formality, though one strongly influenced by the political parties, rather than genuinely interested parties. It suffers from a number of conceptual and practical shortcomings: it does not provide a reason for the fact that physician assisted suicide remains illegal whereas euthanasia, a seemingly greater act, has been decriminalised, nor does it have in place a rigorous system of safeguards. It also remains significantly under-enforced. Taken together, these things provide strong evidence that a significant change in moral thought has occurred in Belgian society, leading to strong political will to liberalise policies surrounding the end of life, and a very weak will to pursue transgressors of these new laws in court, or to even adequately determine who is breaking the law. This is also evident in the 2014 amendment to repeal the age restriction on access to euthanasia, something which perhaps reflects the incrementalism the original drafters of the law had in mind. Despite all these concerns, worries about organ procurement from euthanasia patients remain to be properly substantiated by data. This is something which should be studied close-

[127] More recent data suggests that euthanasia now accounts for 1.6-1.8% of deaths. *See* http://www.consciencelaws.org/background/procedures/assist018.aspx [Accessed 27 June 2017].

[128] Cohen-Almagor, *op. cit*. p. 517.

ly in the coming years. Notwithstanding, to conclude, euthanasia in Belgium remains a concern because physicians do not abide by the laws which control it, continue to practise physician-assisted suicide and, most worryingly, non-voluntary euthanasia, with almost complete impunity. Nations considering decriminalising euthanasia must learn from this. Is it possible to regulate euthanasia so as to prevent its abuses, risks and harms? The case of Belgium appears to indicate that the answer is no.

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Medical Malpractice Web Advertising: A Qualitative, Cross-sectional Analysis of Plaintiff Medical Malpractice Firms in Suffolk County, Massachusetts

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ABSTRACT: Medical malpractice plaintiff firms play a central role in the prosecution of malpractice claims. There have been limited studies on the online advertising practices of plaintiff medical malpractice firms. The Martindale-Hubbell directory was used to identify all plaintiff medical malpractice firms in Suffolk County, Massachusetts. Each firm's website was individually mined for relevant data. Thirty-one unique medical malpractice law firms were identified. Seventy-seven percent of law firms advertised awards with the Martindale-Hubbell AV rating, AVVO, and Super Lawyer being the three most common. The second most common method of advertising was accomplished through descriptions of successful verdicts and settlements (61%). A total of 408 verdicts, settlements, and arbitrations collectively representing $1.4 billion dollars were advertised by all law

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firms. Median awarded values for verdicts was advertised as $4.5 million, while the median awarded values for settlements was $1.25 million. Defendants most commonly practiced obstetrics (18%), followed by primary care (14%). Law firms report treatment and diagnosis delay as the most common successful claim (50%), followed much further by misdiagnosis (8%), and communication error (4%). Our sample correlates with larger claims-based studies surrounding the most commonly sued specialties, however, median reported settlement and verdict values were significantly higher in our cohort. Considerations should be made to provide advertising guidelines for medical malpractice plaintiff firms.

Medical malpractice remains a highly relevant issue in health policy. Even though the overall rate of malpractice claims per physician have fallen in the past 10 years,[1] some experts suggest that current cost-reducing strategies in Accountable Care Organizations may lead to more medical liability claims.[2] One area of medical malpractice that remains understudied is the advertising practices of medical malpractice firms. A study published in 1994 identified the single most important driver of plaintiff contact with medical malpractice law firms as direct advertising to consumers.[3]

In 2016, Congressional leaders and the American Medical Association (AMA) have identified mass-media advertisements by plaintiff medical malpractice law firms seeking clients who have suffered from medical-related adverse events as a threat to public health;[4] in 2015, $1283 million USDs were spent on 360,000 ads by law firms seeking plaintiffs for lawsuits against medical device and pharmaceutical manufacturers.[5] One common target is the drug rivaroxaban (Xarelto). Rivaroxaban is an oral Factor Xa inhibitor that serves as an anticoagulant; it is FDA-approved in the prevention of thrombosis in patients with atrial fibrillation. Recent reports have directly tied adverse patient events including death from pulmonary embolism to law firm advertising practices scaring patients into stopping rivaroxaban without consulting their physician.[6] The disproportionate emphasis on medication side effects without adequate description of its benefits can lead to patient discontinuation of necessary, and sometimes life-saving medications.[7] In response, the AMA is drafting legislation calling for advertisers to include appropriate and conspicuous warnings against discontinuing medications prematurely.

Contemporary law firm advertising is one area of medical malpractice that is poorly understood. The American Bar Association has published guidelines on ethical legal advertising with an explicit ban against barratry,[8] colloquially known as ambulance chasing. As part of tort reform, Oklahoma and Texas have gone as far as to criminalize barratry. Analogous to medicine, the AMA provides guidelines to physicians in regard to ethical advertising practices.[9] These guidelines lack specificity but advise against physicians stating misleading comments, including the omission of necessary material information. In general, commercial advertising, including legal and medical services,

are regulated by the Federal Trade Commission, which states that only truthful and reasonable claims are allowed.

Recent scholarship has argued for more regulation of health professional advertising beyond the basic consumer protection laws outlined by the Federal Trade Commission, due to inherent information asymmetry among specialized professions and the potential for patient harm.[10] Analogously, law is another specialized profession with significant information asymmetry. In particular, medical malpractice incorporates specialized knowledge of both fields, which makes consideration of advertising practices unique. In order to better understand online advertising practices of plaintiff medical malpractice firms, we conducted an analysis of firms in Suffolk County, which is the most populous county in Massachusetts. Massachusetts has had near universal health insurance coverage since 2008 and serves as a model state reflective of nationwide reforms to expand health coverage.[11]

Methods

The Martindale-Hubbell directory of law firms was accessed on April 17, 2015 for law firms listed under "medical malpractice" in Suffolk County, Massachusetts. Fifty-six unique results were returned, and further analysis determined 53 unique firms. Out of 53 firms, 31 met inclusion criteria as firms offering plaintiff malpractice services. Website content for these 31 firms was downloaded on the same day for further analysis. A qualitative coding scheme (available in the supplemental table) was developed and reconciled by all authors. Ten percent of firms were analyzed by two authors to ensure internal consistency.

Results

A total of 56 firms were returned from the Martindale-Hubbell directory. Manual analysis eliminated 25 law firms that were either duplicates or medical malpractice defense firms. A total of 31 unique medical malpractice law firms were identified, which are further described in Table 1. No law firm in this cohort offered services for both medical malpractice plaintiff and medical malpractice defense. Plaintiff law firms had a median number of five lawyers. Medical malpractice certification was limited to a minority of firms.

The main strategies of firm advertising were either by externally branded awards (77%) or descriptions of successful verdicts and settlements (61%). In regards to awards, the Martindale-Hubbell AV rating (55%) and the Super Lawyer Designations (55%) were most commonly reported. Regarding self-reported characteristics, "experienced" was most commonly cited, followed by "successful," "aggressive," and "professional."

Successful verdict and settlement descriptions were the second most common advertising strategy employed by plaintiff law firms. A total of 408 verdicts, settlements, and arbitrations were identified. For 34 settlements and verdicts, no specific monetary award was listed. Only one law firm described an arbitration award. Median awarded values for verdicts was advertised as $4.5 million, ranging from $100,000 to $63 million

Table 1: Descriptive Characteristics of Plaintiff Medical Malpractice Law Firms in Suffolk County, Massachusetts

Law Firm Characteristics	
Plaintiff Law Firms Identified	31
Median Lawyers Per Law Firm	5
Total Lawyers	266
Medical Personnel on Staff	6%
Medical Malpractice Certified	13%
Advertises Verdicts and Settlements	61%
Total Verdicts and Settlements Advertised	408
Offers Free Consultation	68%
Offers Live Chat	23%
Externally Branded Awards	
Externally Branded Awards	77%
Martindale-Hubbard AV Rating	55%
Super Lawyer Designation	55%
AVVO 10.0 Rating	29%
Best Lawyers Designation	26%
USNews & World Report Best Law Firms	23%
Who's Who Designation	10%
Self Reported Descriptive Characteristics	
Experienced	74%
Successful	48%
Aggressive	32%
Professional	26%
Skillful	19%

USDs. For settlements, the median advertised value was $1.25 million USDs. In total, verdicts, settlements, and arbitrations reported by plaintiff law firms in Suffolk County totaled over $1.4 billion USDs. See Table 2 for details.

Table 2: Advertised Awards for Settlements and Verdicts

	Cases Mentioned (#)	**Minimum (millions USD)**	**Maximum (millions USD)**	**Median (millions USD)**	**Total $ Awarded (millions USD)**
Verdicts	72	0.1	63	4.5	532
Settlements	218	0.0	190*	1.3	624
Unspecified Verdict or Settlement	82	0.1	12	1.6	232
Arbitration	1			0.5	0
Verdict or Settlement with Monetary Award Unspecified	34**				

*Includes one class action lawsuit.

**34 verdicts and settlements were reported as won, but without a monetary award specified.

For successful settlements and verdicts, the most common claims were related to delay in diagnosis or treatment (50%). Less commonly, misdiagnosis and medication errors accounted for 8% and 7% of claims, respectively. See Table 3 for details. A minority of claims (4% or less) were attributed to communication errors, direct sexual abuse from a practitioner, errors in monitoring, medical device errors, or laboratory errors. Of these claims, 33% led to death and 39% led to permanent injury.

Table 3: Claim Characteristics*

Claim Characteristics	
Claim Type	
Diagnosis or Treatment Delay	203 (50%)
Misdiagnosis	31 (8%)
Medication Error	28 (7%)
Communication Error	16 (4%)
Sexual Abuse	18 (4%)
Monitoring Error	12 (3%)
Medical Device Malfunction	3 (1%)
Laboratory Error	3 (1%)

* In assessing all claims, 33% were explicitly linked to patient death and 39% were linked to permanent injury. The remainder were unspecified based on available data.

Our results also showed a wide range of medical specialties identified as defendants of successful medical malpractice verdicts and settlements (Table 4). Obstetricians (18%) were most commonly identified, followed by primary care physicians (14%). A subgroup analysis of 75 obstetrics verdicts and settlements with sufficient detail revealed that the majority of cases involved fetal complications (37%), followed by labor management (11%). Only 2% of obstetrics claims and verdicts were attributed to maternal complications. Ultimately, 34 separate specialties represented 6% or less of all verdicts or settlements described. In terms of defendants, physicians (65%) were the most likely to be sued, but cases involving nurses, residents, and other allied health professionals were also identified. Only a minority of advertised successful verdicts was against pharmaceutical (3 cases) or medical device manufacturers (1 case).

Table 4: Advertised Defendant Type by Speciality*

Physician Practice Area	Mentioned	**Defendant Type**	Mentioned
Obstetrics	75 (18%)	Physicians	285 (65%)
Unspecified Primary Care Physician	59 (14%)	Nurse	33 (7.6%)
Emergency Medicine	25 (6.0%)	Medical Staff, unspecified	29 (6.7%)
Psychology	24 (5.7%)	Residents and Fellows	17 (3.9%)
Diagnostic Radiologist	24 (5.7%)	Hospital	16 (3.7%)
General Surgery	19 (4.5%)	Therapist	12 (2.8%)
Psychiatry	18 (4.3%)	Nurse Practitioner	8 (1.8%)

Pediatrics	16 (3.8%)	Multi-group Physician Practice	7 (1.6%)
Anesthesiology	14 (3.3%)	Midwives	7 (1.6%)
Orthopaedic Surgery	13 (3.1%)	Paramedics	3 (0.7%)
Neonatology	12 (2.9%)	Physical Therapist	3 (0.7%)
Surgery Subspecialty Unspecified	12 (2.9%)	Pharmaceutical Manufacturer	3 (0.7%)
Neurosurgery	11 (2.6%)	Nursing Home	2 (0.5%)
Gynecology	11 (2.6%)	Rehabilitation Center	2 (0.5%)
Internal Medicine	10 (2.4%)	Pharmacist	2 (0.5%)
Medical Oncology	9 (2.2%)	IVF Clinic	2 (0.5%)
Pathology	7 (1.7%)	Physician Assistant	1 (0.2%)
Dermatology	5 (1.2%)	Other	1 (0.2%)
Plastic Surgery	5 (1.2%)	Behavioral Center	1 (0.2%)
ENT	5 (1.2%)	Chiropractor	1 (0.2%)
Gastroenterology	4 (1%)	Medical Device Manufacturer	1 (0.2%)
Ophthalmology	4 (1%)		
Neurology	4 (1%)		
Urology	4 (1%)		
Family Medicine	3 (0.7%)		
Infectious Disease	3 (0.7%)		
Vascular Surgery	3 (0.7%)		
Urgent Care	3 (0.7%)		
Cardiology	2 (0.5%)		
Hematology	2 (0.5%)		
Pulmonary Disease	2 (0.5%)		
Nuclear Medicine	2 (0.5%)		
Gynecologic Oncology	2 (0.5%)		
Reproductive Endocrinology	2 (0.5%)		
Physical Medicine and Rehabilitation	2 (0.5%)		
Cardiothoracic Surgery	2 (0.5%)		

*In terms of obstetrics, the majority of claims pertained to fetal complications (37%), followed by labor management (11%). Only 2% were coded as maternal complications. For surgical complications, pre-operative complication claims (71%) were most common, compared to delay in surgery (28%), intraoperative complications (18%), and postoperative complications (2%).

Discussion

There were 31 plaintiff law firms in Suffolk County, Massachusetts. Collectively, these firms boasted 408 successful verdicts, settlements, and arbitrations totaling $1.4 billion USDs. Compared to a larger 350,000 claims analysis, notable similarities and disparities were identified. In regards to similarities, permanent injury or death

accounted for 72% of claims in our cohort compared to 81% in a study by Tehrani et al. In addition, both cohorts identified obstetrics represents one of the most litigious medical specialties.[12,13]

Diagnosis delays and treatment delays together represented over 50% of all claim types.[13] This has implications in regards to the prevalence of defensive medicine, a practice that costs the U.S. health care system up to $850 billion dollars per year.[14] More than 90% of physicians cite practicing defensive medicine, with medical liability identified as a primary driver.[14] Our results show that the majority of law firms that advertise successful verdicts and settlements identify diagnosis and treatment delay as the most successful claims.

Our data also shows that law firms in Suffolk County report median verdicts and settlements that far exceed median awards from larger studies.[13] In the study by Tehrani et al., the median award was $213,250 USDs (13), compared to $1.25 million USDs per settlement or $4.5 million USDs per verdict in this cohort. This reflects a difference of more than 400%. Although disproportionate advertising of large settlements and verdicts does not imply all cases will have similar outcomes, law firms have a clear incentive to advertise large settlements and verdicts to prospective clients.

There are several important limitations in this study. First, Suffolk County represents only a small subset of medical malpractice plaintiff firms in the country, making generalizability of our results difficult. However, comparisons with larger studies show similarities in respect to specialties sued and claim types, providing some evidence of validity. Second, not all firms in Suffolk County may be listed in the Martindale-Hubbell directory or may operate a website. Third, website data accuracy is unregulated, and descriptions are completely self-reported. Thus, external validation of accuracy is difficult. Lastly, our methodology only focused on advertising within one area of law. Future work should investigate how plaintiff medical malpractice advertising practices online compared with other areas of law (e.g. divorce law or criminal law).

Medicine and law represent two largely self-regulated professions due to a combination of specialized knowledge and societal trust. As physicians and healthcare institutions expand advertising practices, ethical pitfalls arise, such as focusing on salient success cases without providing background probabilities of success.[14] Indeed, medical practitioners should be held to higher standards as well. The proposed Health Care Practitioner Transparency Act (Senate Bill 191 - 2017) would require all healthcare providers clearly present their credentials and licensure to patients, and prohibits advertisements including websites from offering deceptive or misleading information regarding healthcare services. Medical specialty boards are analogous to state bar associations in granting licensure based on a set competency. Further delineation of either legal or medical competency is not provided. Our results show similar pitfalls within the medical malpractice law advertising. For instance, high success rates are likely promoted by plaintiff medical malpractice firms despite the fact that the vast majority of these cases are unprosecuted. None of the websites analyzed in this cohort describe case success rate or probability

of success. Meritless medical malpractice lawsuits still account for 37% of all claims.[12] There is no evidence connecting plaintiff medical malpractice advertising practices to the overall prosecution of medical malpractice lawsuits, broader healthcare costs, or patient harm. However, we must consider the role medical malpractice advertising plays in driving a portion of costs in the U.S. healthcare system.[15]

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Verbatim

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American Association of Pro-Life Obstetricians & Gynecologists and the American College of Pediatricians

Lives Worth Living

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Clinical Issues Related to Children with Trisomy 13 or 18

The clinical picture often painted for parents at the diagnosis of their child with Trisomy 13 or 18 is dismal. Pictures of the most drastic possible facial deformities, conversations about the worthlessness of their child to society, and dismal comments about the "fact" that these disorders are "incompatible with life" are some of the sufferings that parents of children with trisomy 13 or 18 endure. But, what is the reality?

How Long do Children with Trisomy 13 and 18 Actually Live?

The Kaplan-Meier Survival Curve compiles data from Metropolitan Atlanta 1968-1999, and shows less than 10% survival at 1 year. But contrast that to the 1994 article from Baty et al. showing a 40% survival at 1 year. Which is correct?

Problems with Trisomy Survival Data

- Most center based studies are small and suffer from rare incidence skewing statistics and limiting actual predictive power.
- Large registry studies have more data, but are unable to comment on the the care provided to the infants, a confounding factor which greatly alters survival.
- When interventions are compared, no studies report on "non-feeding" of infants as part of the palliative care "treatment."
- When interventions are described, often there are no details given regarding care after post-natal diagnosis such as withdrawal of previous "aggressive" care.
- Many studies include mosaics (even though these are generally only 2-4% of trisomy cases).
- In older studies: the diagnosis of trisomy was often made later, missing some cases that died prior to diagnosis.
- In new studies: the increased number of terminations prior to birth for more severely affected babies might skew toward higher survival rates for those infants who survive to birth.

Survival of Trisomy 13 and 18 in the Current Era

Overall Survival

The 2015 study by Meyer et al. is the largest population-based study of survival among children with T13 or T18 published to date. Data is derived from 9 US States

during the time interval from 1999-2007. The study includes 693 infants with Trisomy 13 and 1113 infants with Trisomy 18. It includes both full trisomies and mosaics.

They found that if the newborn survives to 28 days postpartum, then the subsequent chances of survival to one year is 46% for trisomy 13 and 36% for trisomy 18, and the chances of survival to 5 years is 38% for trisomy 13 and 33% for trisomy 18. These findings were confirmed by Nelson et al. who found similar long term survival rates. They also found large regional variations in survival, illustrating that the care given to the infants is a large determining factor in long term survival.

Congenital Heart Disease

Peterson et al. reviewed cases from the US Pediatric Cardiac Care Consortium (PCCC) from 1982-2008. They found 50 patients with trisomy 13, (of which 29 underwent intervention) and 121 patients with trisomy 18 (of which 69 underwent intervention).

In hospital mortality for patients with trisomy 13 were 27.6% and for patients with trisomy 18 were 13%. This is a 10x higher mortality rate as compared with the general surgical population for all surgical categories. However, post discharge, the survival rate of the patients with trisomy 13 and trisomy 18 was higher than previously reported.

In summary, care and treatment of patients with Trisomy 13 and 18 clearly increases their long term survival rates, as clearly demonstrated in the literature. However, the attitudes of medical personnel, and their ignorance of clinical data serve to discourage parents from giving this care.

Attitudes of Medical Personnel Toward Patients with Trisomy 13 and 18

Among Canadian cardiologists surveyed by Young, 70% of respondents would recommend comfort care only to Trisomy 18 newborns with a simple cardiac lesion, which increased to 75% for a complex lesion. Surprisingly, if the case were their own child with Trisomy 18, and the child were in-utero, 65% would terminate the child, and 22% would recommend comfort care only. If their child were diagnosed as a newborn, 85% would do comfort care only and only 15% would do a repair.

Yet this attitude is not carried over to the treatment of other disorders with comparable survival rates. For example, the survival rate of neonates who are born at 24 weeks is similar to the survival rate of trisomic neonates. Yet most neonatologists would not recommend comfort care only to this cohort of patients. And the 5 year net survival of patients diagnosed with brain, lung and pancreatic cancers is similar to the 5 year survival for trisomic neonates, yet oncologists routinely treat these patients, and do not automatically refer them for euthanasia or comfort care only. So clearly there is an additional factor other than survival influencing the attitudes of medical professionals toward patients with Trisomies.

The attitude among obstetricians and neonatologists is equally uninformed and dismal. Wilkinson et al. reported that 84.5% of 948 obstetricians still believed that Trisomy 18 was a lethal anomaly, with 54.2% agreeing that T18 was “incompatible with

life," and 44% agreeing that neonates with T18 should not be resuscitated at birth. This disparity in lethal and incompatible life reveals the troubling truth. For many obstetricians T18 is "lethal" because they do not believe a T18 life is one worth living. Perlman et al. reported that 56% of neonatologists would not initiate resuscitation of newborns with trisomy 18 and congenital heart disease. The authors derided neonatologists who would resuscitate such infants for an "abdication of responsibility."

The attitude among nursing personnel is also disparaging. Janvier et al. reported that 58% of delivery room nurses would pursue termination for their fetus with trisomy 21 (Down syndrome) and 71% would recommend a termination for Trisomy 18.

Why the Shift in Medical Professionals Attitude? The Bioethical Revolution

Medical professional ethics for the last 2000 years have been formed by the Hippocratic Oath, which formed the basis of the revered "doctor-patient relationship." The Oath formed the basis of this relationship of trust, because those who have taken the Hippocratic Oath have vowed by all that they hold sacred to always act to help and never to harm their patients, including to never perform or suggest either abortion or euthanasia.

In the 1960's and 70's, with the legalization of abortion, a number of new "oaths" appeared. These "oaths" were reviewed by Crawshaw et al., with remarkable statements such as:

- no mention of prohibition of either abortion or euthanasia
- variable references to "higher interest," "justice," "it may be within my power to take a life; this awesome responsibility must be faced with great humbleness...."
- "I treat a sick human whose illness may affect the person's family and economic stability."
- "I am a member of society with special obligations to all my fellow human beings, those of sound mind and body as well as the infirm."

The current attitudes about trisomic patients reflects the utilitarian attitudes characterized by an emphasis on the welfare of the "family or community" as the primary focus of the medical professional, as well as the acceptance of the attitude that there is a duty for some to die. This shift was explored by Smith in his discussion of "futile care theory," as well as by Jonsen, who describes bioethics as primarily a "social movement." Callahan, founder of the *Hastings Center Report* on the "Bioethic Revolution" states: "*The first thing those in bioethics had to do was push religion aside." "The final factor of great importance was the emergence ideologically of a form of bioethics that dovetailed nicely with the reigning political liberalism of the educated classes in America."* Confirming this attitude is a telling 1970s editorial from the *California Medical Journal* which stated:

> The traditional hard choices will have to be made with respect to what is to be preserved and strengthened and what is not, and that this will of necessity violate and ultimately destroy the traditional Western ethic with all that this portends. It will become necessary and acceptable to place relative rather than absolute values on such things as human lives, the use of scarce resources, and the various elements

> which are to make up the quality of life or of living which is to be sought. This is quite distinctly at variance with the Judeo-Christian ethic.

The march of the utilitarians has multiple modern leaders, but this exemplifies the current thinking of mainstream bioethics:

> Because many humans lack properties of personhood or are less than full persons, they are equal or inferior in moral standing to some non-humans. If this conclusion is defensible, we will need to rethink our traditional view that these unlucky humans cannot be treated in the same ways we treat similar non-humans. For example, they might be aggressively used as human research subjects and sources of organs. [Beauchamp, Failure of theories of personhood]

> If criteria such as the costs (social, psychological, economic) for the potential parents are good enough reasons for having an abortion, even when the fetus is healthy, if the moral status of the newborn is the same as that of the fetus and if neither has any moral value by virtue of being a potential person, then the same reasons which justify abortion should also justify the killing of the potential person when it is at the stage of a newborn. [Giublini, After birth abortion]

When the authors of the prior article were severely criticized, their response was a chilling non-apology apology:

> When we decided to write this article about after-birth abortion, we had no idea that our paper would raise such a heated debate. 'Why not? You should have known!' people keep repeating everywhere on the web. The answer is very simple: the article was supposed to be read by other fellow bioethicists who were already familiar with this topic and our arguments [as]...this debate has been going on for 40 years. [Giublini, Defending after birth abortion]

The "40 year debate" was spurred on in no small part by the "Georgetown Mantra" which defines bioethical decision-making as limited to autonomy, beneficence, justice and non-malfeasance. These four concepts were implemented with no mooring in the sanctity of human life. In a relativistic world, these four can be used to justify any action and any outcome. This "mantra" has been taught as "bioethics" in medical and nursing schools for decades.

Increasingly, autonomy appears to rule, especially in cases where individuals seek to end the lives of a child, a loved one or themselves, as exemplified by Brittany Maynard. Beneficence, justice, and non-malfeasance are increasingly employed variably to override decisions to continue medical care in difficult cases (Charlie Gard). Many hospital based ethics committees have assumed the role of quasi-judicial bodies. This is the inevitable result of "bioethics rational analysis" on the bases of no predetermined ideology. Noted bioethicist Albert Jonsen noted that bioethics is a "social movement with a view toward the formation of public policy."

How Does the Prevailing Bioethical Morass Affect Parents Whose Baby Has a Trisomy?

Guon investigated the comments heard by parents from medical professionals when the parents chose to continue pregnancies after the diagnosis of a trisomy:

- "Your baby will likely die before or at the time of birth." (94% of parents)
- "Your baby will not live more than a few months." (88% of parents)
- "Your baby's condition is lethal or incompatible with life." (93% of parents)
- "Your child will be a vegetable." (55% of parents)
- "Your baby will destroy your family or marriage." (28% of parents)
- "If your baby survives, his/her life will be meaningless" (55%) or "a life of suffering." (68%)

Some parents described the pressure to abort:

> "I found out that my daughter had Full Trisomy 18 when I was 18 weeks pregnant. OB's asked me 3 times to terminate, told me none of these babies survive to birth and if they did it was only for a few hours. I was even asked 'Why would you want to give birth to a baby that is going to be of no use to society?'"
>
> "When we got the diagnosis I was asked if I minded waiting until tomorrow for the termination!?!"
>
> "An OB asked me if I wanted to burden my other kids with such a sibling. Another doctor (Ob/Gyn) told me these children lacked the will to live, that they were without a soul, unable to experience being alive."

Some parents described the pressure to not pursue newborn interventions:

> "I was told by a neo no one with trisomy 18 had EVER survived. I was told if somehow he did survive, he would ruin my life. I was told he would have no quality of life."
>
> "We found out about trisomy 18, days before we left for a trip to Africa. We were told 'It doesen't matter where you give birth, the outcome will be the same for the baby-whether an elite hospital or the African bush.'"
>
> "A GYN asked me if I had any children and I told him I had a daughter, about 9 mos old at the time, with F T18. "Oh", he said with a sad face, "So you're just counting down the days, huh?"
>
> "There's a dark cloud coming for her."

Palliative Care for Trisomy 13 and 18 Patients

There is a difference between palliative care and hospice care. Palliative care is care given to improve the quality of life of patients who have a serious or life-threatening disease. Treatment continues as the medical condition continues to be assessed. In contrast, hospice offers medical care toward a different goal: maintaining or improving the quality of life for someone whose illness, disease or condition is unlikely to be cured. The focus is on caring, not curing. Generally there is not concurrent care in the US. [http//www.cancer.gov/about-cancer/advanced-cancer/care-choices/palliative-care-fact-sheet#q5].

Janvier 2016 surveyed 332 parents on trisomy support social networks, who answered questions about their 272 children. Healthcare providers recommended "comfort care" at birth in all prenatally diagnosed cases. Life-sustaining interventions "as for any other child" was chosen as a plan of care by 25% of parents. Of great significance, prenatal diagnosis was the strongest NEGATIVE independent factor associated with longevity: 64% of fetuses with a prenatal diagnosis died in less that 24 hours, only 47% survived to be discharged to home. This is in strong contrast to infants diagnosed after birth. In infants diagnosed after birth, only 1% died in less than 24 hours and 87% survived to be discharged to home ($P<0.01$).

The immediate care given to children after birth differed significantly. Those children diagnosed prenatally were given: warmth, skin to skin care, medication for comfort. Children who were diagnosed after birth at a median age of 6 days had the usual newborn interventions which included oxygen, ventilation, tube feeding and IV fluids. *With only one exception, death in the first 24 hours of life was exclusively seen in children who had been diagnosed prenatally.*

The authors comments are revealing:

> "It seems palliative care for children with prenatal diagnosis is directed to a goal of having as short a survival as possible after delivery."
>
> "Survival for trisomy infants is possible after a short trial of respiratory support."
>
> "Parents of almost half the children discharged on comfort care later decided to consider surgical interventions, because their child exceeded expectations. Most parents had been told their child was 'incompatible with life' and would live a meaningless life of suffering."
>
> "It seems to us that neither a universal imposition of comfort-care nor a universal application of intensive care and invasive surgery is appropriate."

As clinicians, we need to:

- with equipoise carefully examine the currently available data.
- evaluate and communicate the current status of practices related to care from palliation to intensive interventions.
- rise above our personal prejudices.
- listen to the voices of families imploring us to consider their opinions regarding the value of the life of their child with trisomy 13 or 18.

The Tyranny of the Self-Fulfilling Prophecy in Trisomy 13 and 18

A false description of a circumstance evokes behavior that makes the original false conception come true. "The specious validity of the self-fulfilling prophecy perpetuates a reign of error" [Robert Merton] When a condition is predicted as lethal, potentially life-saving treatments are withheld. As a result, patients who might have survived will then die, perpetuating the belief that the condition is lethal. Lethality begets lethality. [McCaffrey 2011]

Why Physicians Often Challenge Parents Who Fight for the Life of Their Children?

- Many of us have been erroneously taught that these children do not survive to be born…beyond an hour…beyond a day…beyond a month…beyond a year….
- Many of us have not seen a child with trisomy survive.
- Some do not believe that the mental disabilities characterizing trisomy are worth living with ("beneficience").
- Some personally view severe disability as equal to suffering and pain ("beneficence", non-malfeasance").
- Some believe they are able to see what parents cannot regarding the future.
- Some do not believe resources should be "wasted" on these babies ("justice").

A Tale of Three Trisomies: Selecting the Road Previously Not Taken

Until the 1980's Down syndrome was characterized as severely life-limiting, a life with little meaning and institutionalization was encouraged. Disability rights groups organized for those with special needs. The medical literature underwent a profound ideological transformation from describing children with Trisomy 21 as "defective mongoloids" to "mongoloids" to "trisomy 21" to "Down syndrome." However, delays in diagnosis of AV malformations and failure to repair the malformations despite acceptable levels of pulmonary vascular resistance persisted into the 1990's.

Statements similar to the old statements about Down syndrome are currently promulgated regarding patients with trisomy 13 and 18. As with Down syndrome families, trisomy 13/18 families are committed to loving potentially technology dependent children with significant impairments. Trisomy families, with the support of social media, are mandating transparency and truth from us as medical practitioners. Boss et al. states:

> Many clinicians object to life-sustaining treatment of infants with trisomy 13 and 18. These views are based on 2 ideas. First, that these trisomies are uniformely fatal or lethal conditions. Second, that the burdens of treatment under these circumstances outweigh the benefits. *These views are no longer tenable*. Many infants with these trisomies survive for years. Many parents report that infants with trisomies have an acceptable quality of life and are valued members of families. -John Lantos

Thus the accurate description for trisomies 13 and 18 is "Life-Limiting Conditions."

Parental Views of Their Children with Trisomy 13 and 18

Janvier in 2012 described how parents view their children, which stands in stark contrast to the medical professional's opinions they had encountered. Of the families with a full trisomy 13 or 18, 40% lived over a year, 21% lived at least 5 years. For parents of children who had died, 89% reported that their overall experience of their child's life was positive. In families where a child lived longer than 3 months, 50% stated that their child experienced more pain than other children. 50% recognized that caring for a special needs child was more difficult than they thought it would be, but 98% reported that this child enriched their lives. Of families with other children, 82%

felt that this child had a positive effect on siblings. When all parents were asked if they would continue another pregnancy if they discovered they were expecting another child with trisomy 13 or 18, 83% said they would not end the pregnancy.

Clinical Questions in Caring for Infants with Trisomy 13 and 18

- Optimal delivery…? Csection vs vaginal delivery?
- Antenatal steroids for PTB?
- Central apnea treatment? Caffeine?
- Types of supportive measures and benefits?
- Cardiac and more complex surgeries?

Non-invasive Prenatal Testing—To Test or Not to Test?

It is critically important for informed consent purposes to convey the difference between screening tests (high false positive rate) and diagnostic tests in terms of sensitivity, specificity, false positive and false negative rates. Currently available cell free fetal DNA testing has only about a 50% positive predictive value at best. This is a screening test which, for younger mothers, where the trisomy conditions are less prevalent, offers results that have extremely low positive predictive values. A mother wants to know if this test is positive, is it really positive for me? For trisomy 13 and 18, this test is far less accurate than a coin flip. Yet some patients are making clinical decisions to end the life of their child based on inaccurate screening tests alone.

The Way Forward for Hippocratic Professionals

Given the uniqueness of the circumstances involving life-limiting prenatal diagnosis, parents need a local community responsive to the distinctive needs which present prenatally and post-natally. There are no "private" decisions; every choice affects the people in a family, their friend, their local community—and this includes the medical community. The amount of support a family receives drives their decisions. The nature of these "supports" can be a source of courage, love, and hope, or a source of despair. Whether parents are encouraged to hope or despair depends largely on the character of the community in which parents are embedded.

Communities engendering hope recognize the unique bond of love and trust between a parent and their child. These communities refuse to see the child as a "medical complication" or a constellation of limitations that produce suffering. Rather these communities appreciate the suffering parent's experience while assisting the parents to recover meaning after the disappointment of unfulfilled hopes. These communities recognize the "good" grounded in the virtues of acknowledged dependence promotes genuine human flourishing...they preserve our humanity.

UNC offers an evolving approach to management of these families with children who have Trisomy 13 or 18:

- Multidisciplinary: OB's MFM's Ethics, Chaplains, General Peds, Neos, Peds Surgery, Peds CardioThor Surgery, OB nurses, Peds nurses and house-staff
- Elimination of "lethal" language

- All cases reviewed at High Risk Perinatal Conference
- Parents and families viewed as "partners" in care

Regarding language- Some Suggestions:

- "What is your baby's name? Congratulations!"
- Caregivers provide an honest and up to date appraisal of the data in conjuction with what is actually known about that baby.
- "What do you hope for? What are your expectations?" Clarifying expectations with families provides for joint caregiving with same goals.
- "We will share this journey with you."

And finally:

From *Clowns of God:*

> "I know what you are thinking. You need a sign. What better one could I give but to make this little one whole and new? I could do it, but I will not. I am the Lord and not a conjurer. I gave this mite a gift I denied to all of you-eternal innocence. To you she looks imperfect–but to me she is flawless… She will never offend me, as all of you have done. She will never pervert or destroy the work of my Father's hands. She is necessary to you. She will evoke the kindness that will keep you human. Her infirmity will prompt you to gratitude for your own good fortune.
>
> More! She will remind you every day that I am who I am, that my ways are not yours, and that the smallest dust mite whiled in the darkest spaces does not fall out of my hand… I have chosen you.
>
> 'You have not chosen me.'
>
> 'This little one is my sign to you.'
>
> 'Treasure her!'"

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Framing the Conversation for Exploring Innovative Techniques in Fetal Therapy: The Example of Bilateral Renal Agenesis

William Polzin, M.D.

Current Status and Limitations to Common Interventions for Fetal Anomalies

The Cincinnati Fetal Center had its inception in 1999. Full collaborative services between Obstetric and Pediatric providers were offered beginning in 2001. Full fetal intervention services that included open fetal surgery began in 2003. The Cincinnati Fetal Center is on par with other comprehensive centers in North America, most located within the United States. There are comprehensive centers worldwide, most offering select interventions that are best described as provider specific.

A "comprehensive center" is one which has the ability to offer consultative care including imaging, diagnosis, adjunctive testing and fetal interventions while being able to care for the mother and the newborn over the entire spectrum of the gestation. The neonatal care system must be able to provide additional supportive and therapeutic interventions. Access to this kind of care is difficult, and not universal, even in the USA. Most Centers have benefactors that help support patient access.

The Cincinnati Fetal Center (CFC) has offered over 4757 consultations as of June 2016. By far the most common consultation has been for twin-twin transfusion syndrome (TTTS) (1587 consultations); followed by bladder outlet obstruction (274); congenital pulmonary airway malformation (CPAM) (260); congenital diaphragmatic hernia (CDH) (254); myelomeningocele (MMC) 243; fetal tumors (99); Twin reversed arterial perfusion sequence (TRAP) 92; Amniotic band syndrome (ABS) 44.

Through June 2016, CFC offered 1149 fetoscopic procedures; 102 radiofrequency ablations (RFA); 61 open fetal surgeries; 56 ex utero intrapartum treatments (EXIT); and 47 c-sections with ECMO standby, in addition to procedures on placenta support, shunts and amnioports. We have had no severe maternal complications.

Twin Twin Transfusion Syndrome (TTTS)

In the treatment of twin-twin transfusion syndrome, the following options are offered:

- Selective termination, fetal reduction
- mnio reduction alone (reduce polyhydramnios) variable results
- Fetoscopic laser photocoagulation- this is the standard treatment and improves survival and outcomes.

Out of 1587 TTTS evaluations (including 87 triplets) 895 fetoscopic laser coagulation cases were performed. From July 1, 2011 to June 30, 2016, the survival rate of at least one twin following the fetoscopic laser photocoagulation procedure was 91-92%. Survival of both twins was 61-77%, with an overall survival rate of 76-81%.

Fetal Urinary Tract Obstruction

The etiologies of fetal urinary obstruction include: posterior urethral valves (PUV), urethral atresia, cloaca and urogenital sinus anomalies, prune belly syndrome, uretero-pelvic juncture (UPJ) obstruction, ectopic ureter, ureterocele and a list of others. Between 2006-2010, CFC offered vesico-amniotic shunts, fetoscopy, or open fetal surgery for these anomalies. The overall survival beyond the first few days of life is 68%, but varies depending on the presence or absence of amniotic fluid: 96% survival if amniotic fluid is restored, compared with 48% survival if oligohydramnios or anhydramnios persists.

Etiologies for persistent oligohydramnios or anhydramios include: (1) Displaced or occluded shunts, shunt malfunction as manifested by distended fetal bladder, hydroureter or hydronephrosis; and (2) Disease progression of end stage renal disease (ESRD) or as the presenting finding due to renal dysplasia, as manifested by the lack of urine production confirmed by oligohydramnios, and an empty fetal bladder or decompressed renal pelvis with shunt in place.

Congenital Diaphragmatic Hernia

In the surgical treatment of congenital diaphragmatic hernia, the outcomes of treatment at CFC are equal or surpass the reported outcomes in the CDH study group. For a Type A defect, CFC had 100% survival, compared to CDH study group survival rate of 98%. For type B defect, CFC had 100% survival compared to CDH study group survival rate of 95%. For type C defects CFC had a 96% survival compared to a 78% survival in the CDH study group. For type D defects, the survival rate of both CFC and the CDH study group was 57%. From 2010 to 2016, percentage of patients who survived after ECMO has increased (from 22.7% to 77.8%) while total numbers of patients requiring ECMO has decreased. This compares favorably with results from other centers.

In 20011, Jan DePrest published the outcomes of the Eurofetus network as it related to severe forms (liver up and LHR O/E <25%) of congenital diaphragmatic hernia (CDH) showing only a 17% survival. In North America, the survival rate was better (40%), but not ideal. For moderate CDH, the neonatal survival was remarkably better in North America (71% v. 55%), but morbidity in survivors was as severe and long-term survival

was <50%. For this reason, alternative strategies were considered applying a technique developed over a decade ago, called fetoscopic tracheal balloon occlusion (FETO). Using this balloon occlusion technique between 27 and 29 6/7 weeks with removal during the 35th week, the survival rates for severe CDH are markedly improving. This work continues today in North America with 7 sites offering the procedure.

Oligohydramnios

The etiologies of oligohydramnios are multiple, and can be divided into Primary Fetal causes and Secondary obstructive causes.

Among the primary fetal causes of oligohydramnios are:

- Bilateral renal agenesis
- Bilateral multicystic dysplastic kidneys (MCDK)
- Autosomal recessive polycystic kidney disease (ARPKD)

Among the secondary obstructive causes of oligohydramnios are:

- Lower urinary tract obstruction (LUTO) or bladder outlet obstruction (BOO) caused by posterior urethral valves (PUV), urethral atresia or cloaca and urogenital sinus anomalies.
- Bilateral uretero-pelvic junction obstruction
- Prune belly syndrome
- Megacystis microcolon
- others

But, the most common cause of oligohydramnios in general obstetrical practice is PROM-premature rupture of membranes. This is by far and away the most common cause of oligohydramnios.

Amnioinfusion in the setting of PROM

There has been considerable promise in the literature of treatment of PROM with serial amnioinfusions. Ogunyemi [*Eur J ObGyn RepBio* 2002; 101: 167-72] published a controlled trial of 12 treated vs untreated PROM cases with weekly amnioinfusion from 17-27 weeks. Authors found increased perinatal survival and decreased neonatal sepsis. Similarly, DeSantos *FDT* 2003; 18(6): 412-417] published a series of 71 cases, of which 34 were treated with weekly amnioinfusion. They found increased latency, EGA at delivery, birthweight and gestational age.

Fisk reported the outcomes of 61 pregnancies with and without documented PROM. 58 had successful amnioinfusion; 9 of which were infused from 18-27 weeks. Of those 9 patients, 2 had LUTO, 3 had idiopathic oligohydramnios, and 4 had PROM. Of the 9, there were three survivors and 6 perinatal deaths. But 5 of the 6 deaths had no evidence of pulmonary hypoplasia on pathology report.

Tchirikov [*J Perinat Med* 2013; 41(6): 657-63] used an implantable reservoir which allowed for continuous infusion of fluid with antibiotics. Of seven treated patients, 5 survived, with a PROM to delivery mean of 49 days.

A recent metaanalysis of randomized and observational studies showed enough promise in these techniques to recommend appropriately powered prospective trials. [*Am J Obstet Gynecol* 2012; 207:393.e1-11]

Animal and human data drive the evidence that the canalicular phase of fetal lung development (16 to 26 weeks) is the critical period for lung development. However, no animal studies or human case experience gives answers as to how late is too late to help. Therefore currently (and historically) clinical intervention is not strictly limited by gestational age.

Intervention can be geared toward a population of patients, who at the time of diagnosis and evaluation, want the opportunity for their child to be a pulmonary survivor. This, in effect, delays the need to decide if renal impairment is the turning point. However, most families don't have adequate counseling from providers. If adequate counseling is offered to families, most families will become valuable participants in the family decision. [Warady: *Am J. Kidney Dis* 2014; 64:128-42]

Bladder Outlet Obstruction (BOO) and Posterior Urethral Valves (PUV) both can present with severe hydronephrosis and anhydramnios. Multicystic Displastic Kidneys (MCDK) presents as bilateral multicystic dysplastic kidneys, urinary bladder non-visualization, small chest with small lungs and anhydramnios. Multicystic Dysplastic Kidneys (MCDK) presents as bilateral multicystic dysplastic kidneys, with non-visualization of the urinary bladder, small chest with small lungs and anhydramnios. Autosomal Recessive Polycystic Kidney Disease (ARPKD) presents with large echogenic kidneys with multiple tiny cysts, oligo- or anhydramnios, decompressed bladder and small chest. Bladder Outlet Obstruction (BOO) can lead to fetal end stage renal disease (fESRD).

The use of a vesico-amniotic shunt to relieve urinary obstruction was evaluated from 16 papers, non-randomized case series involving 342 patients:

- 210 shunts were attempted, 206 successful.
- 28 complications
- 80% had oligohydramnios
- failure to restore amniotic fluid resulted in 100% mortality
- overall survival rate was 47% (>40% had ESRD)

[Coplen 1999, Freedman 1996, Lipitz 1993, Manning 1991, Crombleholme 1990, Elder 1987]

Results from CFC data from 2006 to 2010, in fetal patients who had vesicoamniotic shunt, fetoscopy, or open fetal surgery demonstrated an overall survival within the first few days after firth of 68%. There was 96% perinatal survival if amniotic fluid was restored. There was 48% perinatal survival if oligohydramnios or anhydramnios persisted.

The assessment today is that both BOO associated with fESRD and primary fESRD are almost uniformly fatal due to pulmonary hypoplasia without restoration of amniotic fluid. In very selective cases parents are counseled about serial amnio-infusion to permit a "pulmonary survivor." Amnioport placement in highly selective cases affords a simple appoach to restore and maintain normal fluid volume, and may allow for

pulmonary survival. This procedure also gives patients another option to trans-uterine serial amnioinfusion.

Since 2010, patients with oligohydramnios secondary to LUTO or primary renal disorders who oligo- or anhydramnios were offered amnioport as a primary procedure in the cases of renal dysplasia with no or inadequate urine production. The parents were counseled that this was considered an unproven therapeutic innovation performed specifically to try to benefit their fetus. IRB approval was obtained to maintain information and access records for data collection. Those offered an amnioport were highly selected and extensively counseled for the care their infant would require in the NICU and beyond.

Since 2010, 15 patients were considered for an amnioport, and 8 elected to proceed. One patient had a second port placed after the first one dislodged. There were no fetal deaths. All 8 had successful restoration and maintenance of amniotic fluid. Delivery ranged from 9 to 96 days after placement (mean 63.7 days). One died due to unrecognized laryngeal web. One died of pulmonary hypoplasia after preterm premature rupture of membranes at 31 5/7 weeks. None of the remaining 6 had pulmonary hypoplasia.

In very selective cases, parents are counseled about serial amnio-infusion to permit a Pulmonary Survivor. Proposed candidates are:

- Patients that have had fetal intervention but develop fESRD
- Patients who present with severe oligohydramnios or anhydramnios and poor urinary markers
- Patients with primary fESRD (Renal dysplasia, Polycystic Kidneys, MCDK, ARPKD, or Bilateral renal agenesis).

Candidates undergo extensive counseling with MFM, Neonatology, Nephrology, Urology, Transplant Surgery, Social Workers, Ethical Oversight Committee. Parents are informed about:

- Risk of IUFD, prematurity and neonatal death despite the amnioport
- Pulmonary survivors may require immediate neonatal renal replacement therapy after birth
- Challenges of neonatal renal replacement therapy
- Need for renal transplantation
- Complex care and management.
- Candidates then go to a separate consent meeting.

The Amnioport is placed by transuterine catheter insertion into the amniotic space via maternal laparotomy. This is an OFF LABEL USE of an FDA approved device.

The CFC Experience with the Amnioport

Between 2004 and 2015, CFC evaluated >240 fetal patients with bladder outlet obstruction. Since 2010, 27 patients were considered for amnioport placement. Nine chose comfort care and 2 elected serial percutaneous amnioinfusions.

Sixteen patients had 17 amnioports placed. The first patient required a second amnioport due to early dislodgement, resulting in subsequent modification of the technique to reduce the risk of dislodgement.

In the 16 patients that had amnioports placed, only 1 had good prognosis by classic criteria:

- 8 male fetuses with posterial urethral valves of which 6 had cystic dysplasia on presentation.
- 1 male fetus with dysplastic horseshoe kidney
- 1 male fetus with bilateral cystic dysplasia
- 1 female fetus with bilateral cystic dysplasia
- 1 female fetus with VACTERL (cloaca, right renal agenesis, ventricular septal defect) and had a laryngeal web prenatally
- 1 female fetus with PKD
- 2 male fetuses with BRA
- 1 male fetus with unilateral RA dn contralateral dysplastic kidney

The average gestational age at port placement was 24 wks (range 21 3/7 -30 wks). There were no post-operative infections, chorioamnionitis or IUFD's. Two patients with perioperative PROM resealed within 1 week. The amnioports all worked to successfully restore amniotic fluid volume for time ranging from 8-93 days. Average gestational age at delivery was 331/7 weeks (range 295/7-37 weeks) Two patients are currently pregnant at 274/7 weeks. (both are serial infusions one with BRA and one with bilateral dysplastic kidneys.) Delivery dates ranged from 9-93 days after placement (mean 59.5 days).

Ten of the 16 fetal patients have died: Two from pulmonary hypoplasia, one from combined pulmonary and cardiac causes, four from complications of renal disease, one from airway malformation. The female fetus with VACTERL and an unrecognized laryngeal web died in the delivery room. This female underwent only 2 amnioinfusions prior to developing PPROM 9 days after amnioport placement and delivered at 31 1/7 weeks. One died of pulmonary hypoplasia after developing PPROM and delivered at 31 5/7 weeks. One died of pulmonary hypoplasia at birth. One died of complex morbidity after withdrawal of support.

Five of the 16 patients survived to discharge on peritoneal dialysis. Three underwent living related donor transplant. One is 22 months onl and on peritoneal dialysis. One survived to discharge without peritoneal dialysis. One is eight months old on peritoneal dialysis.

Future Directions

- Learn and better understand the disease process: Further research is needed into fluid substrates used in the infusion, as well as the pathophysiology of lung development and disease processes. More understanding is needed of prognostic paramenters as well as predictors of response to therapy.
- Track long term outcomes
- Improve patient selection criteria
- Improve patient access to therapy.

Considering Bilateral Renal Agenesis: These Questions Remain Unanswered:

1. Is equal consideration given to the fetus and the pregnant woman?
   a. Who arbitrates the risk/reward benefit
      i. For the fetus?
      ii. For the community?
      iii. For future providers?
   b. Who prevents bias in care delivery by overtly stressed providers as a result of these innovative strategies?
   c. Who declines on behalf of the fetus?
      i. At what age may children decline the obligatory therapy facing them?
2. Should care like this be done only in a research environment?
   a. Recent publication makes the case for counseling pregnant women "guided by deliberative beneficence-based clinical judgment" avoiding any language like "treatment" or "therapy" [*J Perinat Med* 2017; 45(5):585-94].
   b. Given the access to care is limited, will the research be valid?
   c. Given the limited access to research centers, will the research be broadly applicable?
3. How can conflicts of interest be avoided?
   a. Marketing
   b. Financial rewards
4. Do we consider the resource demand these efforts make on hospital systems and on other communities?
   a. Expert care in Obstetrics may lead to newborns that lack neonatal care.
5. How is the positive bias of experienced treatment centers weighed against the negative bias toward a procedure from Centers who expertise is limited?

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3-Parent Embryos, Gene Edited Babies and the Human Future

David A. Prentice, Ph.D.*

The idea of giving the best to our children, and helping them be their best, has long been a quest for parents. Today the quest for the perfect child has turned to genetic manipulation. In the past this was the realm of science fiction—think *Brave New World* or *GATTACA*—but the ability to manufacture a "designer baby" has recently taken a significant step closer to reality. Robert Edwards, primarily known for development of IVF (in vitro fertilization), said in 1999: "Soon it will be a sin for parents to have a child that carries the heavy burden of genetic disease. We are entering a world where we have to consider the quality of our children."

Modern molecular genetic techniques have brought us to the brink of Edwards' consideration of the "quality of our children" and not just in terms of disease. Indeed, James Watson (co-discoverer of the double-helical structure of DNA) in 2001 also suggested opening the door to tinkering with the genomes of our children: "If we could make better human beings by knowing how to add genes, why shouldn't we?" One problem with such sentiment is that there is no direction in terms of who makes such decisions or even the meaning of what constitutes "better human beings."

Human genome manipulation by adding genes actually starts first with identifying, and then screening for, specific genes. As with all of these innovations, the initial screens are designed to detect disease genes or associated mutations. All too often, such screens lead to lethal selection against those with such genetic markers. However, the screening never stops with the original intention, but moves on from definitive disease presence to carrier status or to predisposition, as well as from disease trait to non-disease trait. Whole genome screening has now been done for the fetus in utero.[1] The next step, after simple screening, is the desire to prevent the disease or trait from appearing.

Enter the world of 3-parent and gene-edited babies. Such genetic changes so early in life—at the embryonic stage—are termed "germline" genetic engineering, because the altered genetic traits affect not only the individual but can be passed through the germline to future generations. This is because the genetic change is made such that every cell contains the altered genetics, eventually appearing in egg or sperm.

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The creation of 3-parent babies was originally proposed as a way to "treat" mitochondrial genetic defects, which can be severe, even life-threatening. Mitochondria are the organelles within every cell that are responsible for generation of cellular ATP energy. These small organelles contain their own small DNA genome, encoding 37 genes including 13 essential polypeptides, 22 tRNAs and 2 rRNAs. The mitochondrial proteins are complemented by nuclear-encoded proteins, to form functional mitochondria.[2] Mutations in mitochondrial DNA can lead to various, often severe, diseases, all without current cure.[3] Approximately 1 in 6500 individuals are estimated to have a serious mitochondrial disorder.[4] Mitochondria are inherited through the maternal line, i.e., through the oocyte (the egg).

However, no individual with a mitochondrial genetic disease is actually treated by the current proposals. Rather, new human beings are created with tri-parental genetic contributions in the hopes that they will not possess nor pass on the genetic mutations.[5]

The first such experiment, done at fertility clinics, involved injection of ooplasm from a donor egg into the mother's unfertilized egg prior to fertilization *in vitro*. Over two dozen births attributed to ooplasm transfer were reported by clinics between 1998 and 2002. Mitochondria were transferred as part of the ooplasm, in an attempt to dilute the numbers of mitochondria containing the genetic mutation, resulting in offspring who carry genetic material from three separate individuals—the nuclear genetic mother and father, and the mitochondria/ooplasm donor; the researchers noted that this was "germline genetic modification."[6] Current terminology refers to these individuals as "3-parent babies." The U.S. FDA itself in 2002 called this "*de facto* germ line gene transfer."[7] Both terms are accurate, as the new individual has DNA from three parents, and the new DNA content can be passed to future generations.

Ooplasm transfer is itself associated in mice with decreased viability of offspring as well as other subtle effects on growth and development.[8] Reinhardt *et al*. published a review paper enumerating several potential health hazards due to mitochondrial transfer and mitochondrial heteroplasmy.[9] The health risks they noted include decreased survival, decreased growth, and behavioral and fertility problems. New evidence continues to high-

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light the paucity of information we have regarding mitochondrial-nuclear interactions,[10] *e.g.*, in response to stress,[11] or in relation to signal transduction pathways.[12] While no comprehensive follow-up was done initially for the children created by ooplasm transfer, early reports from one group noted potential chromosomal and behavioral abnormalities.[13] A subsequent survey of parents of the children born of these early experiments indicated no problems observed by the parents, but these limited and admittedly biased data provide little basis to allay concerns regarding these human experiments.[14]

Two papers published from proponents of "mitochondrial transfer" (actually what is transferred is the nucleus, making this a form of human cloning), highlight the ineffectiveness of the techniques in eliminating the genetic mutations. Both Yamada *et al*.[15] and Hyslop *et al.*[16] document that the embryo manipulations still result in carry-over mutated mitochondrial DNA when the new 3-parent human embryos are created, and those mutated mitochondria can multiply in the cells of the newly-created individual such that the genetic disease could still be passed on both to these newly-created children as well as future generations.

Moreover, the current techniques are often misleadingly termed "mitochondrial replacement therapy" yet mitochondria are not transferred—it is neither mitochondrial replacement, nor therapy. In point of fact what is being transferred is the nucleus. Thus the techniques are actually a form of human cloning (nuclear transfer), performed at the earliest stages of development rather than using later stages as the nucleus donor (somatic cell nuclear transfer.) In point of fact, the leading proponents of 3-parent embryo creation are cloners, some of the first laboratories in the world to successfully create healthy cloned human embryos.[17]

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[10] Friedman JR and Nunnari J, Mitochondrial form and function, *Nature* 505, 335, 2014.

[11] Adachi Y and Sesaki H, Cyclin C: An Inducer of Mitochondrial Division Hidden in the Nucleus, *Dev. Cell* 28, 112, 2014; Cooper KF *et al*., Stress-Induced Nuclear-to-Cytoplasmic Translocation of Cyclin C Promotes Mitochondrial Fission in Yeast, *Dev. Cell* 28, 161, 2014.

[12] Garipler G *et al*., Deletion of conserved protein phosphatases reverses defects associated with mitochondrial DNA damage in Saccharomyces cerevisiae, *Proc. Natl. Acad. Sci. USA* 111, 1473, 2014.

[13] Barritt et al., Epigenetic and experimental modifications in early mammalian development. Part II. Cytoplasmic transfer in assisted reproduction. *Human Reproduction Update* 7, 428, 2001; and Barritt et al., Rebuttal: interooplasmic transfers in humans, *Reproductive Biomedicine Online* 3, 47, 2001.

[14] Chen SH *et al.,* A limited survey-based uncontrolled follow-up study of children born after ooplasmic transplantation in a single centre, *Repro. Biomed. Online* 33, 737, December 2016.

[15] Mitsutoshi Yamada *et al.*, "Genetic Drift Can Compromise Mitochondrial Replacement by Nuclear Transfer in Human Oocytes," *Cell Stem Cell* 18.6 (June 2, 2016) 749-754, doi: 10.1016/j.stem.2016.04.001.

[16] Louise A. Hyslop *et al.,* "Towards clinical application of pronuclear transfer to prevent mitochondrial DNA disease," *Nature* 534.7607 (June 16, 2016): 383-386, doi: 10.1038/nature18303.

[17] Tachibana M et al., Human embryonic stem cells derived by somatic cell nuclear transfer, *Cell* 153, 1228, 2013; AND Yamada M et al., Human oocytes reprogram adult somatic nuclei of a type 1 diabetic to diploid pluripotent stem cells, *Nature* 510, 533, 2014.

The two main techniques currently used are Maternal Spindle Transfer[18,19,20] and Pro-Nuclear Transfer.[21] An additional technique, similar in methods and outcome that may be considered, is Embryo Cell Nuclear Transfer (Blastomere Nuclear Transfer).[22] All of the proposed techniques foster human cloning as well as genetic manipulation of nascent human beings.

In Maternal Spindle Transfer, eggs from the intended mother (with mutated mitochondria) and eggs from a donor (with healthy mitochondria) are harvested. The nucleus is removed from an egg of the intended mother and from a donor egg. Then the nucleus from the intended mother is placed into the ooplasm of the donor egg, and the reconstituted egg is fertilized with the intended father's sperm.[23]

Pro-Nuclear Transfer, by contrast, starts with creation of two single-cell embryos using IVF. Embryo #1 uses the intended mother's egg and intended father's sperm, and contains mutated mitochondria. Embryo #2 uses a donor egg and donor sperm or sperm from the intended father; this embryo has healthy mitochondria. The pro-nuclei (egg and sperm nucleus, prior to their fusion into a zygote nucleus) are removed from both embryos. The pro-nuclei from Embryo #1 (from the intended parents) are then placed into the cytoplasm of the donor embryo; this recombined embryo now has the intended mother's and father's nuclear genetics and healthy mitochondria from the donor.

Embryo Cell Nuclear Transfer (Blastomere Nuclear Transfer) is equivalent to somatic cell nuclear transfer (cloning of an adult), but transfers the nucleus of an embryo cell into an enucleated egg (cloning of an embryo). The donor egg has healthy mitochondria.

Despite significant concerns for the ethics of such human germline genetic manipulation, the U.K. approved projects to genetically manipulate human embryos both in the mitochondrial DNA and in the nuclear DNA. In the U.S., the Institute on Medicine judged that germline mitochondrial DNA manipulation (3-parent embryo creation) was ethically justified and communicated that decision to the FDA, which had already received applications to do such manipulations clinically and transfer the embryos to the womb.[24] However, the U.S. Congress in 2015 added an amendment to funding legislation that prohibits FDA approval of human gene editing, including creation of

[18] Tachibana M et al., Mitochondrial gene replacement in primate offspring and embryonic stem cells, *Nature* 461, 367, 2009.

[19] Tachibana M et al., Towards germline gene therapy of inherited mitochondrial diseases, *Nature* 493, 627, 2013.

[20] Paull D et al., Nuclear genome transfer in human oocytes eliminates mitochondrial DNA variants, *Nature* 493, 632, 2013.

[21] Craven L et al., Pronuclear transfer in human embryos to prevent transmission of mitochondrial DNA disease, *Nature* 465, 82, 2010.

[22] Bredenoord AL et al., Nuclear transfer to prevent mitochondrial DNA disorders: revisiting the debate on reproductive cloning, *Reproductive BioMedicine Online* 22, 200, 2011.

[23] For a visual primer describing various proposed methods, see "'3-Parent Embryos' and 'Gene-Edited Babies': A Visual Aid," Charlotte Lozier Institute, https://lozierinstitute.org/3-parent-embryos-and-gene-edited-babies-a-visual-aid/.

[24] Reardon S, US Panel backs '3-person' embryos, *Nature* 530, 142, 11 February 2016.

3-person embryos. The Aderholt amendment provides a pause for consideration of how, or whether, germline genetic manipulation should take place in the U.S.[25]

Despite the urgings for caution, and in an attempt to go around U.S. law, a New York fertility doctor created 3-parent human embryos and did the embryo transfer in Mexico to avoid legal prohibitions.[26] A subsequent publication shed only minimal light on the details of the procedure, supplying some information on the numbers of embryos manufactured using the 3-parent embryo technique, and initial results of examinations of the child born.[27] He was supposedly healthy at 7 months old, but the DNA tests (done only 2 days after birth and not repeated) show some tissues with much more mutated mitochondrial DNA than predicted. Initial estimates were hopeful that the level of mutated DNA would be minimal (0-2%), but the paper reports levels in some tissues over 9% mutated DNA, and most tissues untested. Higher levels of mutation are indicative of physiological problems. While the researchers say they plan to assess the child's general health on a routine basis until he is 18 years old, the parents are expressing their desire for no more DNA tests. This is not just experimentation on human beings; the child IS the experiment.

Interestingly, once the news became public, the research team admitted to an earlier attempt at nuclear transfer and genetic manipulation of human embryos in China in 2003, but without achieving a live birth, and belatedly published some of the information about the previous experiment.[28] Subsequent reports indicate that other researchers are attempting similar 3-parent baby creation in countries where the procedure is not prohibited, such as Ukraine.[29] Moreover, these new reports of 3-parent babies are not attempts to prevent mitochondrial genetic disease, but are being touted as improvements in overcoming infertility, especially due to aging. The U.S. FDA has started to crack down on potential spread of these genetic experiments, sending a warning letter to the New York clinic doctor who birthed the first 3-parent baby.[30-31]

[25] Prentice DA, Modest but Meaningful Protection from Human Embryo Genetic Manipulation, *Townhall* Dec 17, 2015; accessed at: https://townhall.com/columnists/davidaprentice/2015/12/17/modest-but-meaningful-protection-from-human-embryo-genetic-manipulation-n2094746.

[26] Reardon S, 'Three-parent baby' claim raises hopes — and ethical concerns, *Nature News* 28 Sept 2016, https://www.nature.com/news/three-parent-baby-claim-raises-hopes-and-ethical-concerns-1.20698.

[27] Zhang Z *et al*., Live birth derived from oocyte spindle transfer to prevent mitochondrial disease, *Repro. Biomed. Online* 34, 361, April 2017.

[28] Zhang J *et al*., Pregnancy derived from human zygote pronuclear transfer in a patient who had arrested embryos after IVF, *Repro. Biomed. Online* 33, 529, October 2016; *see also* Cohen J and Malter H, The first clinical nuclear transplantation in China: new information about a case reported to ASRM in 2003, *Repro. Biomed. Online* 33, 433, October 2016.

[29] Dockrill P, World-First in Ukraine as 'Three-Parent' Baby Born to an Infertile Couple, 19 January 2017, http://www.sciencealert.com/world-first-in-ukraine-as-three-parent-baby-born-to-an-infertile-couple.

[30] Johnson LA, Doctor told to stop marketing 3-person baby technique, *AP* Aug 5, 2017; https://apnews.com/5bc282c9b40e4bbfb6c3540447bd4385/Doctor-told-to-stop-marketing-3-person-baby-technique.

[31] FDA, Advisory on Legal Restrictions on the Use of Mitochondrial Replacement Techniques to Introduce Donor Mitochondria into Reproductive Cells Intended for Transfer into a Human Recipient, Au-

Gene Editing of Nuclear DNA

Gene editing of human beings—of nuclear DNA—has taken place for several decades but has recently received great attention due to development of more powerful and accurate enzyme systems that facilitate genetic engineering. These newer enzyme systems are targeted nucleases that provide efficient cutting of double-stranded DNA with a precision previously unavailable, making directed genetic engineering much more likely. The three current nuclease systems that are most promising are ZFN's (zinc finger nucleases), TALEN's (transcription activator-like effector nucleases), and the CRISPR-Cas complexes (clustered regulatory interspaced short palindromic repeats-CRISPR associated system.)[32] While these nuclease systems are much more accurate in targeting of DNA cuts, even the highly-touted CRISPR-Cas system is not 100% efficient or reliable.[33]

Gene editing uses in humans provide potential paths for repair of genetic or even epigenetic problems. There are many current examples for use of the CRISPR-Cas system and similar enzyme systems that show promise for actual treatment of patients with existing genetic conditions. These pre-clinical studies and clinical trials show the potential for ethical use of gene editing technology to benefit patients, because they are targeting postnatal treatments for patients and are designed to affect the individual treated, yet not enter the germline. For example, one group has used a viral vector with preference for infecting cardiac and skeletal muscle to deliver the components of CRISPR-Cas9 into muscle cells of postnatal *mdx* mice; the *mdx* mouse is an excellent genetic model for human Duchenne muscular dystrophy, showing similar DNA mutations as well as disease symptoms. By delivering the gene-editing enzyme into affected cells of the postnatal mouse, the nuclease carried out the snipping and replacement of a specific portion (exon 23) of the mutated dystrophin gene within the targeted cells. The levels of successful in vivo genetic correction were low (a few percent of the muscle cells), but even these low levels of functional dystrophin gene expression produced enhanced muscle function for the treated mice.[34]

Another promising avenue for genetic engineering that is currently under development is construction of what are termed chimeric antigen receptor-T cells (CAR-T). These cell-based therapeutic techniques are designed to assist a patient's immune system

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gust 4, 2017; https://www.fda.gov/BiologicsBloodVaccines/CellularGeneTherapyProducts/ucm570185.htm; *and see FDA* enforcement letter to John Zhang, August 4, 2017; https://www.fda.gov/downloads/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/ComplianceActivities/Enforcement/UntitledLetters/UCM570225.pdf.

[32] For a review see, *e.g.*, Maeder ML and Gersbach CA, Genome-editing Technologies for Gene and Cell Therapy, *Molecular Therapy* 24, 430–446, March 2016; and Gaj T *et al.*, ZFN, TALEN, and CRISPR/Cas-based methods for genome engineering, *Trends in Biotechnology* 31, 397-405, July 2013.

[33] *See, e.g.*, Barrangou R, Cas9 Targeting and the CRISPR Revolution, *Science* 344, 707, 2014; and Peng R *et al.*, Potential pitfalls of CRISPR/Cas9-mediated genome editing, *FEBS Journal* 283, 1218, 2016.

[34] Long C *et al.*, Postnatal genome editing partially restores dystrophin expression in a mouse model of muscular dystrophy, *Science* 351, 400, 2016.

in attacking and resisting cancer.[35] One technique used to construct these cells involves genetic modification such that the normal antigen-detecting protein on a T lymphocyte (the "antigen receptor") is combined with an antibody portion that targets the specific cancer or leukemia cells in the patient. This chimeric antigen receptor (chimeric because it combines part of the cancer targeting antibody gene with part of the normal T cell activation gene) is able to specifically target and attack the individual's cancer; multiplication of this CAR-T cell produces an army with the mission to attack the patient's cancer cells. Other genetic modifications can also be added to equip the immune cells with other useful features in the treatment of the cancer. A version of this system was used recently to successfully treat a young leukemia patient.[36]

Given all of the promise and potential for use of genetic techniques to heal, it is unfortunate that some are targeting human embryos for genetic engineering. The newer genetic tool, CRISPR-Cas, has already been used in an attempt to genetically engineer early human embryos. Chinese researchers have published three reports on their use of gene editing tools, including a recent experiment on viable human embryos.[37,38,39] And now a U.S. researcher has reported a similar experiment on normal human embryos, including statements on his desire to gestate and birth some of these gene-edited children.[40] Perhaps unsurprising, this researcher (Mitalipov) is also the one who has done human embryo cloning and has advocated for gestation of 3-parent embryos.

One view of the implications of these experiments is that genetic engineering of humans, and particularly of embryos, is inevitable.[41] This viewpoint says that genetically modified (GM) children are the future, perhaps an ethical good, and our aim should be to control such technology using regulation. This attitude views any germline genetic engineering, both gene-editing and 3-parent embryos, in the same light.[42] Others take the view that any human germline gene editing is unwise and ethically troubling.[43] Some parents and children who might benefit from genetic engineering also take the

[35] Qasim W et al., "Molecular remission of infant B-ALL after infusion of universal TALEN gene-edited CAR T cells," *Science Translational Medicine* 9.374 (25 January 2017): eaaj2013, doi: 10.1126/scitranslmed.aaj2013.

[36] Jennifer Couzin-Frankel, "Baby's leukemia recedes after novel cell therapy," *Science* 350, 731, November 15, 2015.

[37] Discussed in: David A. Prentice, "Science," *National Catholic Bioethics Quarterly* 15.3 (Autumn 2015): 567–568.

[38] Xiangjin Kang *et al*. "Introducting precise genetic modifications into human 3PN embryos by CRISPR/CAS-mediated genome editing." *J. Assist. Reprod. Genet*. 33.5 (May 2016): 581-588, doi: 10.1007/s10815-016-0710-8.

[39] Lichun Tang *et al*., "CRISPR/Cas9-mediated gene editing in human zygotes using Cas9 protein," *Mol Genet Genomics* (Published online 1 March 2017): *in press*, doi: 10.1007/s00438-017-1299-z.

[40] Ma H *et al.*, Correction of a pathogenic gene mutation in human embryos, *Nature* published online 2 August 2017, doi:10.1038/nature23305.

[41] Tetsuya Ishii, "Germline genome-editing research and its socioethical implications," *Trends in Molecular Medicine* 21, 473, August 2015.

[42] I. Glenn Cohen *et al.*, "Transatlantic lessons in regulation of mitochondrial replacement therapy," *Science* 348, 178-180, April 2015.

[43] Edward Lanphier *et al.*, "Don't edit the human germ line," *Nature* 519, 410-411, March 2015.

view that they would rather not be engineered.[44] Our human future remains a fragile, open question that needs serious discussion.

[44] Erika Check Hayden, Tomorrow's children, *Nature* 530, 402, 25 February 2016.

Surrogacy, the Handmaid's Tale, and Reproductive Ethics: Egg Donation, Sperm Donation and Surrogacy

Jennifer Lahl, R.N., M.A., President The Center for Bioethics and Culture

The Center for Bioethics and Culture has produced several documentary films which deal with different aspects of third-party reproductive ethics. The first film, *Eggsploitation*, discusses the risks of egg "donation" for healthy young women. Often egg donors are lured into donation by promises of money, without discussion of the risks, knowledge of the lack of any long-term studies, and without understanding of the role money plays in informed consent as well as the conflict of interest of the doctors who are using the donor simply for her eggs. The second film, *Anonymous Fathers Day*, discusses the difficulties encountered by donor-conceived children, now grown up and who do not have any relationship, nor possible relationship, with their biological father. This can lead to intense psychological struggles over biological identity. And the anonymous fathers also struggle with being the parent of children they will never know. The third film, *Breeders: A Subclass of Women?,* presents the stories of four women who made the decision to serve as surrogate mothers and one woman born of a surrogate contract pregnancy. This film addresses the questions of attitudes toward women in general ("Are women easy-bake ovens?") as well as the health and psychological risks to all involved, especially the best interest of the child(ren) born of an arranged contract pregnancy. The disruption of mother-child bonding and family disruption and consequences are also addressed in the film. The three films discuss interrelated cultural and ethical implications of third-party conception arrangements as well as policy recommendations for how as a society we should proceed

Brief History of Reproductive Technology

AI: The first case of artificial insemination (AI) occurred in the 1790's. By 1954 AI was accepted by the general public as an option in the treatment of infertility, and was legal by the mid 1960's.

IVF: The case of Louise Brown (1978) brought the world's attention to the possibility of combining sperm and eggs in a petri dish to achieve fertilization.

Both IVF and AI were eugenic in their inception.

IVF with Egg Donation: The first case of IVF with donor eggs was performed in Australia in 1983 by Dr. Alan Trounson. Trouson was later brought to California to run the California Institute of Regenerative Medicine (CIRM) which was funded by ballot proposition 71 to conduct human cloning and embryonic stem cell research. Many fertility doctors have moved into this field as they have a career built on making life in the laboratory.

Deconstructing Our Reproductive Bodies

The overriding theme of the last 5 decades has been a deconstruction of bodily reproduction, which started with the advent of the birth control pill, designed to allow for sex without procreation. Reproductive technology then sought the next logical step: procreation without sex. We took the embryo out of the womb, then we took gametes out of our bodies. Everything imaginable is now conceivable.

Today: The New Modern Family

Reproduction today is a moral and ethical chaotic landscape with these new modern assisted reproductive technologies opening the door to a whole host of problems.

- Global, chaotic, unregulated fertility industry
- Post-menopausal pregnancies
- Litter births - Octumom
- Twiblings and Triplings
- "Selective Reduction"
- Preimplantation Genetic Diagnosis (Search and Destroy)
- "Savior siblings"
- Single mothers by choice
- Single dads by choice
- Co-parenting
- Homosexual parenting
- Gamete "donation" both inter-familial and anonymous
- Grandparent surrogacy
- And yet, since the birth of Louise Brown the overall success rate of IVF cycles sits at 30%.

Breeders: A Subclass of Women

The demand for eggs and wombs has spawned an industry which preys upon young women, commodifying their bodies and using their naivete and financial need to profit from trafficking in their bodies.

What the women hear from the marketeers:

- The surrogate is "an angel" who helps build an otherwise infertile family.
- Legal issues are rare and can be taken care of by regulation and "good contracts."
- Contracts will protect surrogates.
- It's easy for surrogates to detach from the children they have carried.
- Surrogacy makes no difference to the body of the surrogate ("safe").

The Reality of Surrogacy the women are often not told:

- Surrogates are often forced to give up the children they want to keep.
- Surrogates are often threatened and bullied to "do the job" they were hired to do.
- Surrogacy commercializes procreation.
- Surrogacy exploits poor women in third-world countries and low income women in the U.S.
- The womb is not arbitrary—gestation matters.
- Gestational mothers bond with the babies they carry. Surrogacy discourages bonding important for the child.

Surrogacy is a kind of human trafficking—Reproductive Trafficking—trading over female reproductive body parts. This reproductive trafficking has spawned a multi-billion dollar a year reproductive tourism industry, which sees reproduction as consumerism and commodification of a woman's body. This global reproductive trafficking is a global problem which calls for an international solution.

Take Action

Advocating for women requires that we communicate the harms of reproductive trafficking to a wide audience base. The message must reach legislative, academic and political arenas, as well as the media and general population. Think about your audience, and communicate this message.

Grief, Bereavement, and Traumatic Stress as Natural Results of Reproductive Losses

Naji Abi-Hashem, M.Div., M.A., Ph.D., IABMCP, BCETS

Grief is a universal human experience. Life is a series of gains and losses, attachments and detachments. Some are healthy and gradual while others are unhealthy and abrupt. Sudden losses, unexpected traumas, and intrusive tragedies are most difficult to handle and process. They can be disorienting, destabilizing, and devastating to the whole person, family, organization, or community.

Experiencing loss, grief, and trauma is always difficult, tender, and painful. People normally avoid difficult emotions and unpleasant memories. Major losses and traumatic events come in different shapes, forms, degrees, and intensities. They generate a wide range of reactions and responses on the mental, emotional, behavioral, social, and existential levels. They also affect our mood, function, and mental outlook and impact our relationships and roles within the family, community, or society (Abi-Hashem, 1999a, 1999b, 1999c, 2012; Attig, 2010; Figley, 2012; Gordon, 2013; Lindemann, 1944; Osterweis, Solomon, & Green, 1984; Pearlman, et al., 2014; Rando, 1988; Worden, 2009.

Definition of Terms

Defining the concepts, themes, connotations, and terminologies before discussing them is always important for any meaningful discussion and comprehensive understanding. Because some terms are similar, yet not identical, they are used interchangeably in the literature (cf. Abi-Hashem, 1999a, 2012, in press; Conway, & Valentine, 1988; Figley, 2012; Murray, 2016; Rando, 1988; Smelser, 2004; Strength, 1999; Wolfelt, 2003; Worden, 2009):

Grief is a deep sorrow, an aching of the soul and a torment of the mind. It is an overwhelming sense of loss, which normally results in anguish and emotional suffering. Grief feels like a stranger and an intruder as it engulfs the personality like waves. It can actually be described as a process and an outcome at the same time.

Loss is a sense of deprivation or painful separation from the beloved – a person, object, function, place, or idea. It can be minor or major, sudden or gradual, tangible or symbolic, single or multiple, real or perceived, expected or unexpected, ambiguous or anticipatory, private or public, local or communal.

Bereavement is the state of having suffered a loss. It is being in a sad condition and a sober realization that something essential is missing, which at times shatters the world of the survivor(s).

Mourning is the outer expression of the internal experience of grief. It is the public show of affection or behavior that releases the agony of the heart and of the mind. It is socially and culturally formed as each society has its own ways and rituals for expressing sorrow and deep sadness.

Trauma is an unusual troubling event, which generates substantial anxiety, acute stress responses, sense of horror, and overwhelming helplessness. It can be mild, moderate, or severe in nature. It can be experienced in a single or multiple episodes. Like the other key terms, trauma is experiential on the conscious and unconscious level and is conceptualized by both the subjective and objective criteria of the people and communities involved.

Reproductive Losses are referred to as any absence of innate function, missing of a promised child, or a tangible loss surrounding the natural human cycle of propagation. That includes fertility, conception, pregnancy, delivery, or birth. That is true time-wise (chronologically), meaning before, during, or after the infant is conceived and born as well as months after the actual birth. Such losses can be voluntarily or involuntarily. They cover a wide range of reproductive activities and misfortunes, like inability to conceive, miscarriage, failure of fertility aids and devices, stillbirth, perinatal-neonatal failure, birth abnormalities, sudden infant death, physical disability, etc. They also include maternal death (mother dying during or shortly after giving birth) and any interruption and dysfunction of the normal-natural *process of the human reproduction system*. On the other hand, these losses are true when there is a *planned decision* to dismiss the unborn through *abortion* or to relinquish the newly born to another parent or family through *adoption*.

Tragedy can be perceived as a major calamity, a dreadful accident, a strong adversity, a fatal event, a grave moral failure (as ethical downfall), a violent death, a social dilemma resulting in shame, an agonizing loss caused by violence, an enduring experience of war and destruction, or an invading painful event that fragments the reality of the survivors. Tragedy and disaster have several shared elements.

Disaster is a sudden, hazardous, or catastrophic event that brings great physical destruction and psychological damage to people and their communities. It can be a natural (e.g., volcano, earthquake, storm, flood, fire) or human-made disaster (e.g., attack, riot, explosion, fighting, plague, killing, war).

Meaning Attached to Reproduction & Pregnancy

Naturally, we assign meaning to our lives, functions, relationships, and activities. We also set certain expectations of others and ourselves. We have our hopes and dreams as well as our doubts and fears. All those shape the way we act and react, and the way we view the world.

Most women, couples, and families place high value on *pregnancy* as a promise of continuity and a generative way to extend themselves, to reproduce and procreate, and

to project life. They look at it as a celebration along the journey and as a part of many important landmarks of living. Of course, for some others, a pregnancy can be a burden or a stress if they were not in a place to welcome the idea positively and consider it as a happy development. So, they become anxious and overwhelmed and quickly look for alternatives.

The degree of disappointment and sadness is usually proportionate to the degree of hope people place on the object of their expectation – and the higher the expectation, the deeper the disappointment. Similarly, the intensity of grieving reflects the nature of the relationship(s) with what has been lost. The stronger the attachment and more intimate the relationship, the more profound and more intense the grief. Ambivalence and conflicts in relationships normally produce a mixture of feelings and reactions after the separation (Abi-Hashem, 1999a, 1999b, 1999c, 2017; Attig, 2010; Worden, 2009; Wright, 2006; Zamudio, 2016).

Cultural Roots for the Controversy

In society, there is a wide spectrum regarding how to deal with reproductive losses, with two main opposing camps existing on each extreme. Ironically, every party argues their viewpoint and position from a supposedly very caring motive. On one hand, the so-called pro-choice stance argues primarily for the welfare of the mother and her family unit as well as the right of her privacy and individualistic choice. On the other hand, the so-called pro-life stance argues primarily for the welfare of the unborn child, the sanctity of all the living, and the dignity of the human reproductive faculty or organism.

It appears that part of this war of words has to do with semantics and a competition to impose certain concept-meanings on each other. Obviously, like any other social debate, the two camps have created a polarized sentiment on each side of the spectrum with increased tension, accusation, disagreement, and discontent.

Even in the academic literature we find the two polarities and everything in between. Research studies can also have their own biases, because humans conduct them and they are not immune of misconception, rigidity, legalism, and eventually extremism.

In addition, it appears to some observers and social thinkers that such debates are rooted in culture and worldview. The two main social structures, *collectivism* versus *individualism*, mostly known as Eastern versus Western mentality, are very much at work in any debate and do inform the social norms and values, the interpersonal behaviors and relationships, and the ethical-moral decisions of any given group of people or society (Abi-Hashem, 2015, 2017; Smelser, 2004; Triandis, 1995).

Signs & Symptoms of Grief

Depending on the nature and magnitude of the *loss*, psychological reactions may vary in terms of duration and intensity. They may occur together or separate, in or out of sequence, for short or long periods of time. Such reactions include: disbelief, mental disorientation, intense feelings of separation, marked numbness, deep sadness, tendency for excessive irritation and anger, feelings of guilt and self-reproach, various degrees

of apprehension and anxiety (e.g., shortness of breath, restlessness, hollowness in the stomach, tightness in the throat, heart palpitation, sweating, fainting sensation, etc.), all kinds of worries or fears (possibly developing into panic attacks or phobias), bodily tensions and fatigue, marked loneliness, physical aches and pains, intense yearning for the lost person or object, episodes of crying and sobbing, regressive tendencies, mental preoccupation, sleep and appetite disturbances, poor concentration, brooding and rumination, sensing the presence of the lost object or deceased person (seeing, hearing, smelling, touching, etc.), disturbing nightmares and dreams, searching behaviors, clinging to familiar objects and reminders of the lost or completely avoiding all reminders, withdrawal and isolation, break of communication with others, and refusal to be consoled and comforted.

Normally, there is a preoccupation with the images of the deceased person or lost object and a substantial change of usual patterns in the lifestyle of the bereaved-survivor(s). At times, there is a mixture of feelings or a sense of relief after the deceased suffered a long period of physical pain or terminal illness or after a long troubling relationship marked by tensions and interpersonal conflicts.

> Typically, what makes a loss especially devastating is its magnitude, finality, and irreversibility. If what has been lost was originally foundational and essential to the livelihood and psychological stability of the survivor, and if the loss is totally unredeemable or irreplaceable, then the bereavement process will most likely be intense and prolonged, with potential clinical implications in the future. (Abi-Hashem, 1999a, p. 312).

Such symptoms also are equally present after a reproductive loss. According to Strength (1999), elective abortion is often underestimated as a loss. Following an abortion women and couples still have a need to grieve. Although some women/couples fare better than others, Peppers (1988) found that there is a level of grief reaction present, which eventually begins with the decision to terminate pregnancy, similar to the bereavement following involuntary fetal loss or actual infant death. Some women are surprised to encounter minimal grief while others do experience intense and prolonged grief.

Therefore, grief is manifested in different ways depending on our psychological state, the circumstances of loss, available support system, community involvement, and religious outlook. Usually, grief affects us in most of our faculties and areas of functioning: on the emotional-affective level, the mental-intellectual level, the behavioral-habitual level, the relational-interpersonal level, the social-communal level, and the philosophical-existential level. For example, a significant loss or a traumatic event can bring family members closer together and help them bond with their friends, relatives, and community at large. Or it can break the family bond and scatter its members resulting in tension, conflict, separation, and divorce.

Consequently, mourning is natural. We all become bereaved at some point in our lives. We will always have residuals of loss and shadows of grief following us along the way. However, when the normal grieving process remains incomplete and its work unfinished, it may turn into complicated bereavement or disordered psychiatric condi-

tions (e.g., severe depressions and anxieties), which may then require serious treatment, psychotherapy, and medication. Although people often tend to avoid the hard work of healing, they usually are very glad later on that they went through the process with courage. Ultimately, they discover that their lives have also been enriched by the experience, rather than further devastated, and now they can help others along the journey while simultaneously enhancing their recovery and resiliency (cf. Abi-Hashem, 1999a, 1999b, 2011; Attig, 2010; Gordon, 2013; Lindemann, 1944; Osterweis, Solomon, & Green, 1984; Rando, 1988; Worden, 2009; Wright, 2006).

Signs & Symptoms of Trauma

Psychological trauma can be described as a certain force that disturbs the equilibrium and functioning of any organism or a given system. It can cause serious malfunction and damage on both the personal and the communal levels. The word *trauma* is perceived differently among people and that is based upon their psychological awareness, social norms, life experience, emotional tendencies, and cultural background.

Traumatic events can be powerful invaders that shake the stability of life, disturb the neurobiological balance, and remove the familiar aspects of the daily routine. When researchers evaluated people who survived one or multiple traumas, they discovered three time-related effects: The instant-immediate reactions (pressing effect), the intermediate-transitional reactions (integrated effect), and the long term-chronic reactions (unresolved effect) (Abi-Hashem, 2012; Collins & Long, 2003; Joseph & Linley, 2006; Van der Kolk, 2006).

There are variety of trauma types, classifications, connotations, and experiences. These are considered as subtitles or subcategories, like traumatic stress, secondary trauma, acute stress disorder, vicarious trauma, post traumatic stress disorder, complex trauma, traumatic bereavement, cultural aspects of trauma, etc. During and immediately after a traumatic event, people usually manifest severe anxiety symptoms, certain patterns of detachment or dissociation and other acute responses. Traumatic events are usually threatening because they are outside our usual human-range of experience.

The common symptoms of trauma include the following:

- re-experiencing the fears and helplessness;
- remembering and reliving certain aspects of the traumatic event or tragedy;
- struggling with recurrent flashbacks and intrusive thoughts, strong enough as if the trauma episode is happening all over again;
- persistent avoidance of any reminder associated with the devastating event;
- inability to recall many important circumstances and details surrounding the event;
- displaying psychic numbness (flat emotions) and restricted repertoire of feelings;
- experiencing sleep disturbances and recurring nightmares;
- increased arousal and frequent hyper-vigilance especially following the trauma or tragedy;

- exaggerated responses upon any exposure to a situation that somewhat resembles the first traumatic incident.

Unlike suffering a major loss or significant bereavement when grieving people can contain some of their symptoms and conceal their reactions for a while (in order to resume their life responsibilities or to pretend they are fine and functioning normally), traumatized people cannot do that successfully. This is usually due to the severity and acuity of the emotional and biological symptoms, which happen and surface more involuntary than in the state of grief (Abi-Hashem, 2012; Collins, & Long, 2003; Daugirdaite, Van den Akker, & Purewal, 2015; Figley, 2012; Meichenbaum, 2006; Murray, 2016; Smelser, 2004; Wallin-Lundell, et al., 2013).

What Determines the Severity of Reactions?

The following are among the most prominent factors that determine the kind of psychological responses people might have following a loss, tragedy, or traumatic event: (a) the timing and magnitude of the event, (b) the pre-existing mental-emotional conditions of the people involved, (c) the circumstances of loss, death, or trauma, (d) the nature of relationship and the level of attachment to the lost object or deceased person, (e) the experience of handling previous losses, major crises, and adversities, (f) the availability of a healthy support system before, during, and after the stressful event, (g) the personality traits and temperaments of the survivors, (h) the type of expectations people hold of themselves, others and life in general (realistic versus unrealistic), (i) the socioeconomic status of the bereaved and traumatized individuals, families, or groups, (j) the turn of events after the loss or tragic event, (k) the existential hope and spiritual faith of the people, and finally, (l) the cultural background, heritages, norms, and traditions of the survivors.

Steps Toward Grief Resolution

A successful grief counseling process consists of the following phases, steps, mediators, and procedures:

1. Helping the bereaved person, couple, family, or group to admit that the loss has taken place and it is final. Many survivors refuse to accept that the loss actually happened let alone its finality and irreversibility. That is due to the natural defense mechanism called *denial*. Most people accept some facts about the loss merely on an intellectual but not emotional level.
2. Helping the bereaved people experience and express a range of emotions and feelings, private thoughts and memories, including the pleasant and the unpleasant, related to the lost object, function, or person. This will prevent the limited coping mechanism of *suppression*. Experiential activities and exercises, like role-modeling or empty-chair technique, are very useful and beneficial in facilitating mourning.
3. Helping the bereaved to release the lost object or the deceased person by gradually saying good-bye, setting free, and letting go... This will reverse the

process of *clinging* to what has been lost. First, focus on what the bereaved misses about the lost and help them treasure any fond memories they have. Then, help the bereaved face the other side of reality by focusing on what they do not actually miss about the lost person, function, or object. With encouragement and probing, the caregiver will guide the bereaved to the new situation, confront the full reality of loss, de-idealize what has been lost, and reconcile the opposite emotional polarities. Usually, this is a turning point in counseling when the survivors realize that the lost object or person was not perfect. Then, begin to coach the grieving persons to frequently repeat "good-bye for now" after each encounter, which will eventually prepare them to say "good-bye for good," when they are ready and the time is right.

4. Helping the bereaved to re-invest and re-channel their psychological energy, which has been consumed in the lost, the emotional void, and the mental bargaining to reclaim the lost back, as well as in unsuccessful resolution of the grief, into new relationships, new endeavors, and new projects. Encourage the bereaved to branch out, become involved in their community, develop new interests, practice forgotten talents and skills, engage in productive activities or public service, and focus on new dreams and goals. This will break the condition of *stagnation* and help them transform their pain into purpose, tragedy into treasure, and mourning into mission (Abi-Hashem, 1999a, 1999b; Attig, 2010; Rando, 1988; Worden, 2009).

Steps Toward Trauma Resolution

Try to establish a good relationship alliance and create a warm environment that is inviting and trustworthy. Inquire about them and ask gently for information but not in an interrogative way. Educate people about the nature of tragedy and trauma. Insure each person's safety, survival, and wellbeing as you facilitate their healing. In the case of multiple traumatization or victimization, start with the most pressing one(s). Address target struggles and symptoms and teach clients and survivors basic stress-management skills. Be careful when uncovering intense memories and watch for any overwhelming flood of emotions. Help people see their responses as a measure of self-protection, which can be modified as necessary. Help them contain their exaggerated mental-emotional reactions (anxiety, apprehension, fight-or-flight, overreaction). Introduce emotional expressions in a safe environment. Guide them to reframe their experiences and reconstruct their meaning more realistically. Praise them for any survival abilities, healthy coping, and innate strength they are showing. Help them shift focus from being "victims" to being "survivors." Apply desensitization and teach them relaxation techniques (deep breathing, meditation, mindfulness). Discuss their recovery steps and teach them how to develop healthy self-talk. Prepare them for possible future lapses and sense of discouragement along the way (part of those are normal and expected though should be brief). Help them set new goals, mobilize fresh support, establish new relationships, and reinvest their energy in new endeavors. Encourage them to volunteer services because by helping

others they will help themselves as well. Finally, remain available for support, nurture, consultation, challenge, and comfort (Abi-Hashem, 2012, in press; Collins, & Long, 2003; Figley, 2012; Gingrich, 2013; Joseph & Linley, 2006; Meichenbaum, 2006).

It is important to note here that because most tragedies and traumas have an element of loss and trigger a mourning response, people need time to grieve. Likewise, some losses (but not all) include an element of trauma, especially when they occur during a natural disaster or a tragic accident. Some are results of a violent death, severe abusive treatment, prolonged persecution, or war destruction and devastation. Even if there is no physical or tangible loss involved in the tragedy or trauma, survivors may need to grieve, at least temporarily, the loss of their sense of stability, safety, and security. Then, they have to readjust and readapt to the new reality of life without the lost person, object, function, idea, place, or dream.

In addition, during any caregiving and counseling encounter, it is essential to address both the grief and the trauma reactions simultaneously and to alternate the focus of healing and intervention between their symptoms and struggles. Most of the time, counselors and healthcare providers focus on one area (trauma or grief) and leave the other alone, postpone it till later, or actually refer the survivor to another specialist. However, what makes more sense is to integrate and incorporate approaches at the same time since they are overlapping spheres of the same human experience. It is true that, at times, some symptoms are more pronounced or acute than the others, and the counselor need to deal with them according to their intensity and interference. But the point here is to avoid splitting and compartmentalizing the struggles of the survivors, who are struggling with a host of feelings, memories, thoughts, emotions, behaviors, and agonies. Caregivers definitely need to help the victims and survivors toward both grief healing-resolution and trauma mastery-recovery.

Role of Spirituality in Coping and Recovery

Grief, loss, bereavement, and trauma are profound matters and concerns that usually shake the human life to its core. They are deeply existential issues and raise serious questions and responses. Eventually, what is existential in nature is also psychological, and what is psychological in nature is also spiritual. We cannot divorce the human existence and phenomenological experience one from the other. Therefore, the social norms and habits, moral virtues and values, religious faith and community, cultural traditions and worldview, and spiritual practices and rituals of the victims or survivors play a major role in their understanding, experiencing, and expressing the calamities and adversities of life. They can be great resources for healing and recovery as they provide a sense of hope and transcendence, meaning and purpose, solace, and security. Some people experience a divine presence, a deep peace, and a special comfort with them during and after the troubling events. Others struggle with a crisis of faith or spiritual doubts during the loss or trauma, which is normal and expected outcome, to some degree.

In general, the communities of faith provide vital and necessary emotional and socio-cultural support, sense of belonging and togetherness, solidarity during severe troubles, spiritual confidence and enduring hope, and a renewed fortitude for the future. Besides, many religious traditions have an established set of rituals, symbols, and practices for private and public mourning, along with other welcoming ceremonies and meaningful memorials. Usually, these activities help facilitate grief resolution and trauma recovery and also prevent the suppression of many acute symptoms. Thus, they prevent long-term complications and negative psychological effects, which unfortunately are all too common among many sufferers and survivors.

Sound spirituality, existential outlook, and religious faith can indeed help in the healing and restoration and facilitate personal, familial, and communal growth, thus promoting not only mere coping and survival but also remarkable strength, growing, thriving, and resiliency (cf. Abi-Hashem, 1999a, 2011, 2013, 2017, in press; Chapple, Swift, & Ziebland, 2011; Doka, & Morgan, 2016; Meichenbaum, 2006; Neimeyer, 2011; Shaw, Joseph, & Linley, 2005; Wolfelt, 2003).

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Conscientious Objection to Referral for Reproductive Services

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Conscientious objection in health care is the refusal to participate in, write prescriptions for, perform or refer for reproductive services that may destroy human life. Deeply held moral or religious beliefs may cause physicians and other providers to invoke conscientious objection to the following:

- Abortion
- Contraception
- Emergency contraception
- Physician-assisted suicide
  - Physician aid in dying
  - Medical aid in dying

Oaths for Medical Practice

The Hippocratic Oath has been sworn for several millennia to establish sacred principles of trust between a physician and a patient. Those principles include "doing no harm," working for the benefit of the patient, refusing to give lethal drugs when requested, not to give agents for abortion, and not to do procedures outside of one's training.[1] The Osteopathic Oath, first written in 1938 with minor revisions in 1954,[2] echoes similar values of professional ethics. It begins with the promise to preserve the health and life of the patient and includes giving no drugs for deadly purposes though it be asked. The principal role of the physician as a healer was firmly established through these two oaths.

Over the years, the use of a professional oath has been considered optional by some medical schools, or the oath was changed to reflect changing societal norms. The principles outlined in both the Osteopathic and Hippocratic Oaths are considered out of date by some. Passage of laws that permit both abortion and physician-assisted suicide are not consistent with the oath's tenets. The long-held understanding of the physician as a healer has been modified to reflect the physician as a healthcare agent

[1] Hippocratic Oath https://www.nlm.nih.gov/hmd/greek/greek_oath.html.

[2] Osteopathic Oath http://www.osteopathic.org/inside-aoa/about/leadership/Pages/osteopathic-oath.aspx.

with expected compliance to requests by patients for services that the physician may find objectionable, harmful or lethal.

Moral Distress and the Slippery Slope

The conscience protects moral integrity by providing moral distress when ethical boundaries are breached. The slippery slope in ethics describes increasing comfort with engagement in behaviors that would have caused moral distress prior to participating. As boundaries are crossed, the next boundary becomes easier to traverse.

The slippery slope is evident in attitudes toward abortion after legalization in 1973. Even those who morally objected to abortion struggled for answers to the very few women who found themselves in the most desperate situations. Certainly, providing a way out of a pregnancy for just a few could not be too bad. By 1978, the focus was changing, and posters appeared with captions like, "Join the 1.5 million women in America who have had abortions." The desperate few had become a club to join, and those objecting were shamed for denying women their newly found "right to privacy." Physicians philosophically aligned to the pro-choice agenda were available to provide abortion services for those seeking them. The promoted concept was that the growing embryo was just a "glob of tissue" or a tumor to be removed to relieve the patient of an unwanted burden. If women were educated that the embryo or fetus was indeed a separate living human being, they were most likely to make a life-affirming choice.

As demand for abortion services grew, the numbers of physicians willing to perform the procedure did not keep up with the demand. Even for those sympathetic to a woman's ability to control her fertility, the concept of a woman having the right to abort for any reason at any gestational age, including post-viability caused moral distress for physicians and others, limiting participation. Additionally, laws were passed in many states to restrict access to abortion after viability, or after human characteristics developed, like the ability to feel pain. States with laws more sympathetic to animal rights than rights of the fetus acted with abortion restrictions aimed to create a more civil society.

Decisions in Time of Stress

Some understanding of how human beings react to stress and grief is important in this discussion. During times of stress, the ability to rationally choose the best course of action is impaired. When someone is in crisis, access to counsel from someone not in crisis can help the individual see the big picture and make better decisions. When a woman is unexpectedly found to be pregnant in unfavorable circumstances, disbelief and a desire to reverse the situation may lead to actions that later result in remorse. With time and counsel from others, the woman may realize more options for herself and her offspring than initially apparent. Proponents of choice should not be opposed to women hearing all options for pregnancy, having full disclosure of risks of abortion procedures, and having time to process the best decision for oneself.

Reflection on what the role of a physician should be is appropriate. Traditionally, physicians held the highest moral standards for protection of life and health by treating

diseases and teaching patients preventative care. We should ask the question of what diseases we are treating or preventing with the following, and how physicians could be qualified to participate in determining which human beings will live or die:

- Abortion
- Contraception
- Emergency contraception
- Physician-assisted suicide

Medical Conscientious Objection

> Definition: an appeal to conscience in refusing to do, or seeking exemption from acts that threaten a person's sense of integrity. Patients as well as physicians and nurses may appeal to conscience in refusing treatment or procedures. Called also conscientious refusal.[3]

Some medical ethicists promote the concept that a physician, by virtue of choosing their profession should be willing to perform all procedures within the scope of practice of that discipline at the patient's request. There are serious inconsistencies with this philosophy, as these principles are not universally applied in other situations (like refusing to give a patient antibiotics when requested). Except for reproductive services, it is not standard to consider a physician obliged to provide all services requested by patients. The physician is charged to determine what is in the best interest of the patient's health and well-being, and sometimes that means refusing a requested service. In the United States, legal protections are in place to permit a physician to follow conscience in regard to provision of these services.

Hierarchy of Rights

Fr. Robert Spitzer, former Gonzaga University President, explains the concept of intrinsic and extrinsic rights. Rights are defined as "legal conditions that are necessary or desirable for the fulfillment of human personhood within a state or society. They are obligations of the state or other individuals toward an individual person."

Intrinsic rights are rights that should not be violated. They include those rights outlined by the founding fathers that are "inalienable" including life, liberty, and the pursuit of happiness. They belong to all human beings by virtue of their personhood. They are not a consequence of government decision, and should not be restricted except when actions of the individual dictate a need to protect society (i.e., incarceration when the individual has violated another's intrinsic right). These rights are affirmed in the Declaration of Independence and outlined in the United States Constitution and the Bill of Rights. For Christians, they are rights by virtue of being "made in God's image."

Extrinsic rights are those that may be exercised by mutual consent or legal decree, and are by definition of lesser importance than intrinsic rights. These rights can be taken

[3] Miller-Keane *Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health*, Seventh Edition. © 2003 by Saunders, an imprint of Elsevier, Inc.

away as easily as they were given, and provide a basis for collective self-governance. They should not supersede intrinsic rights, therefore have a lesser value.

In a clash of rights, whose rights win? In a civil society, intrinsic rights should always prevail over extrinsic rights. In the case of abortion, the created "right to privacy" is an extrinsic right created by law. *Roe vs Wade* trumped the intrinsic right of the embryo or fetus to fulfill an extrinsic right of the mother. Physician-assisted suicide laws create a new class of citizens whose intrinsic rights to life are no longer protected in the same way as the rest of the population.

Quality of Life

The assessment of "quality of life" has gained popularity over an absolute value of life. The "quality of life" argument is not necessary in regard to abortion since a woman may choose abortion for any reason. This principle is used to justify physician-assisted suicide, and in other countries is used to justify euthanasia. If a patient makes suicidal ideation known to a physician, there is an obligation to refer for psychiatric services to deal with the patient's despair. Patients with a terminal diagnosis, however, are helped to commit suicide in states where physician-assisted suicide laws have been made "medical care." The clear message from states with physician-assisted suicide laws to patients with a terminal illness is, "Your life no longer has the same value as others. You may consider checking out."[4]

Medical Standards of Care

Standards of care are being written by some bodies to define the right and limits of conscience and refusal of care. Following are examples of standards that have been published in past years that both support and challenge conscientious objection. From the American Medical Association Code of Ethics:

> In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.[5]

From the American Medical Association Policy on Abortion:

> The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures."[6]

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[4] West, Tom H. *Christian Culture and Controversy: Engaging Your World to Make a Difference*. Chapter 1: Right of Conscience. Published by Tom H. West, MD. Taveres, FL and Highlands, NC. 2016.

[5] AMA Code of Ethics, 1.1.7 https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page Accessed 8/1/2017.

[6] AMA Policy on Abortion: https://policysearch.ama-assn.org/policyfinder/detail/Abortion?uri=%2FAMADoc%2FHOD.xml-0-4541.xml Accessed 8/1/2017.

From the American Medical Association Code of Ethics – Physician-Assisted Suicide:

> It is the policy of the American Medical Association that: Physician-assisted suicide is fundamentally inconsistent with the physician's professional role.[7]

American Osteopathic Association Policy on Physician-Assisted Death from the 2016 AOA Policy Compendium:

> The American Osteopathic Association…" opposes legislation that mandates or legalizes individual physician participation in physician-assisted death.
>
> 1997; reaffirmed 2002; 2007; reaffirmed as amended 2012. "[8] The policy was reaffirmed by the AOA House of Delegates July 2017.
>
> Additionally, a resolution to change the osteopathic oath as follows:
>
> "I will give no drugs for ~~**deadly**~~ **ILLEGAL** purposes to any person, though it be asked of me." was disapproved by the AOA House of Delegates.

FIGO (International Federation of Gynecology and Obstetrics) Resolution on "Conscientious Objection" (Kuala Lumpur, 2006):

> FIGO affirms that to behave ethically, practitioners shall:
>
> 1, Provide public notice of professional services they decline to undertake on grounds of conscience;
>
> 2. Refer patients who request such services or for whose cares such services are medical options to other practitioners who do not object to the provision of such services;
>
> 3. Provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well-being; and
>
> 4. In emergency situations, provide care regardless of practitioners' personal objections.[9]

American College of Obstetricians and Gynecologists Compendium of Selected Publications:

> The information in these documents should not be viewed as establishing standards or dictating ridged rules. The guidelines are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or the type of practice.[10]

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[7] AMA Policy on Physician-Assisted Suicide https://policysearch.ama-assn.org/policyfinder/detail/physician%20assisted%20suicide?uri=%2FAMADoc%2FHOD.xml-0-483.xml Accessed 8/1/2017.

[8] AOA Policy Compendium http://www.osteopathic.org/inside-aoa/about/leadership/Documents/policy-compendium.pdf Accessed 8/1/2017.

[9] FIGO, Resolution on "Conscientious Objection" (Kuala Lumpur, 2006). http://www.figo.org/sites/default/files/uploads/OurWork/2006%20Resolution%20on%20Conscientious%20Objection.pdf Accessed 8/1/2017.

[10] ACOG Compendium of Selected Publications Preamble, 2016.

American College of Obstetricians and Gynecologists – Limits to Conscientious Refusal:

The following primary points in their recommendations are given:

1. "….the patient's well-being must be paramount."
2. "Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. "
3. "Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments."
4. "Physicians and other health care professionals have the duty to refer patients in a timely manner…."
5. "In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."
6. "Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service…"
7. Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.[11]

Society of Obstetricians and Gynecologists of Canada Policy Statement:
PREGNANCY TERMINATION/ABORTION

With respect to pregnancy termination/abortion, health care professionals should

1, Be aware of how women can access pregnancy termination, and they must offer timely referrals.
2. Not be compelled to perform pregnancy terminations if this practice is contrary to their beliefs, nor should they be discriminated against if they do provide these services.
3. Be aware that they have an obligation to provide timely, respectful, and appropriate care to women presenting with complications arising from abortion.[12]

It is interesting to note that the organizations representing a cross-section of physicians from many specialties in the United States (AMA and AOA) have developed

[11] ACOG Technical Bulletin #385, November 2007, http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine.

[12] Sexual and Reproductive Health Counselling by Health Care Professionals. SOGC Policy Statement. *J Obstet Gynaecol Can* 2011;33(8):870–871.

policies giving broader conscience rights to physicians, while the policies of the specialty organizations have stronger language requiring participation in objectionable procedures or active referral, and define "emergencies" to include those involving mental health.

Sampling of Current Articles

A review of articles available through Pub Med reveal a variety of opinions on the subject of conscientious objection. Following are some articles with examples of various opinions.

Law, ethics and medicine - Extended essay
Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies

> It is implausible that professionals who voluntarily join a profession should be endowed with a legal claim not to provide services that are within the scope of the profession's practice and that society expects them to provide. We discuss common counterarguments to this view and reject all of them.[13]

Yes we can!...disallowing conscientious objection in reproductive health care
Quote from abstract:

> Reproductive health care is the only field in medicine where health care professionals (HCPs) are allowed to limit a patient's access to a legal medical treatment - usually abortion or contraception - by citing their 'freedom of conscience.' However, the authors' position is that 'conscientious objection' ('CO') in reproductive health care should be called dishonourable disobedience because it violates medical ethics and the right to lawful health care, and should therefore be disallowed.

Note: The article states the acceptable solution to disallowing conscientious objection is not to permit physicians with deeply held moral beliefs opposing reproductive services to participate in specialties where those services are provided. What this in fact accomplishes is denying faith-based patients the right to receive care from a like-minded physician.

It is not true that reproductive medicine is the only field where health care professionals limit legal services that patients request. It is common in various medical specialties to restrict patient access to procedures not beneficial to the patient. Reproductive medicine is the only specialty in which physicians are routinely expected to take human life.[14]

Conscientious objection – to be or not to be

> Article outlines bioethical principles described by Beauchamp and Childress:
>
> - respect for the autonomy of the woman with regard to her reproductive choice;

[13] Schuklenk U, Smalling R. Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *Journal of Medical Ethics* 2017;43:234-240. http://dx.doi.org/10.1136/medethics-2016-103560.

[14] Fiala C, et al. Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care. *Eur J Contracept Reprod Health Care.* 2016 Jun;21(3):201-6. doi: 10.3109/13625187.2016.1138458. Epub 2016 Feb 3.

- non-maleficence (by not leaving her alone in a situation with which she cannot cope);
- beneficence (by helping her to achieve her goals and maintain her physical and psychosocial health);
- justice (by providing medical intervention to every woman in need, independently of sociocultural differences).

Though providing abortions, the author states his personal view:

> The conscientious objector within me would tell me that I am destroying life and therefore acting against a fundamental moral and ethical value. This is true: there is indeed a conflict between my professional and ethical duties towards the woman and my general professional and ethical duties towards emerging life (embryo, fetus). In this conflict, however, my duties towards the woman override all others, because without her body there would be no new life and without her support there would be no good life.

Note: This conclusion proposes that to proceed with terminating the fetus' life is the only action that accomplishes the duty to the patient. It is possible to propose solutions that will lead to better physical health and psychologic well-being of the patient while being life-affirming. The author goes on to make the point that those with deeply held values who show consistency in living out those values should be permitted conscience protections if laws in those countries permit it.[15]

A Hippocratic Response

Delivery of health care should treat or prevent disease. A patient's request for legal services should be denied by those exercising conscience rights when

- The test of risks/benefits is not met
- The service is destructive to human life
- The practice contradicts long accepted medical standards of care (Hippocratic and Osteopathic Oaths)

Recent History of US Conscience Protections

1. HHS Final Rule "Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law" filed in 2008.[16]
2. Obama administration and the ACA weakened many conscience protections
   - Physicians continued with conscience protections concerning abortion and physician-assisted suicide

[15] Johannes Bitzer (2016) Conscientious objection – to be or not to be, *The European Journal of Contraception & Reproductive Health Care*, 21:3, 195-197, DOI: 10.3109/13625187.2016.1156246.

[16] HHS Rule on Health Care Conscience Protection http://www.freedom2care.org/docLib/20090313_HHS_20081218_reg_FINAL.pdf . Accessed 8/8/2017.

- Physicians were not protected from discrimination in provision of abortifacients, contraceptives, sterilizations and other morally objectionable options.
- No protection for medical residents who declined to train for abortions.[17]

3. Presidential Executive Order May 4, 2017 promotes free speech and religious liberty.[18]

How Do We Respond?

Following are some quotes that speak to conscience issues:

- "All that is necessary for the triumph of evil is for good men to do nothing." Edmund Burke (1729-1797)
- "We should not be offering a medical solution to a patient's nonmedical quest." Karen J. Nichols, DO, former president of the AOA[19]
- "In a recent survey of more than 2,800 faith-based doctors, pharmacists, physician assistants and nurses, 95 percent of them said they would quit medicine before violating their conscience." – CMDA[20]

Engage in the Debate:

The following are ways physicians may prepare themselves to defend life:

1. Support organizations that promote life and the conscientious practice of medicine
2. Understand the arguments against conscientious objection to provide a rational challenge
3. Arm yourself with information
4. Speak out where you have a voice
5. Participate in training our next generation of medical professionals
    - Faith based students are delighted to learn that a pro-life physician can practice obstetrics and gynecology
    - Medical students who have not considered these issues can learn other view points during their professional formative years

Conclusions

While many voices in the world are promoting restriction of conscience protections, the United States still holds true to the foundational values of life, liberty and the pursuit of happiness. The recent executive order protecting these rights gives hope that

[17] Imbody, John. Conscience and the New Healthcare Law. http://www.freedom2care.org/docLib/20100913_Consciencegapsinhealthcarelaw.pdf. Accessed 8/8/2017.

[18] Presendential Executive Order Promoting Free Speech and Religious Liberty. https://www.whitehouse.gov/the-press-office/2017/05/04/presidential-executive-order-promoting-free-speech-and-religious-liberty. Accessed 8/8/2017.

[19] Karen Nichols, DO, quoted in Protecting Our Rights of Conscience. *The DO Magazine*. June 6, 2009. http://thedo.osteopathic.org/2009/06/protecting-our-rights-of-conscience/ Accessed 8/1/2017.

[20] Christian Medical and Dental Associations. https://cmda.org/issues/detail/freedom-of-faith-and-conscience. Accessed 8/8/2017.

our nation will remain a haven for those who make protecting life one of their highest values. Recent actions and affirmations of policies in national organizations affirming the physician's role as a healer (not an executioner) gives weight to the conscientious objection platform. Voices promoting procedures and policies that destroy life are loud, intimidating, and will not be easily swayed. While we have seen victories in this arena, there will be continued efforts to push protections away. We must be vigilant in standing for the right and counter efforts to undermine a sacred respect for human life.

The Abortion Agenda in Africa

Ms. Obianuju Ekeocha, M.Sc.

In the last 50 years the idea of legal abortion has crept in and spread throughout the western world. First it was permitted as a mere solution to women suffering or dying as a result of illegal abortions, then during the rise of second wave feminism, its proponents pushed for it to be accepted as an aspect of women's empowerment, however in the last few decades legal abortion has been embraced and elevated by various governments and organizations as a necessary part of women's healthcare.

This has led many western leaders and politicians to champion for government funding of abortion providing organizations as well as subsidized or fully funded abortion services. In the United States of America for example, Planned Parenthood Federation of America which performs about a third of all abortions in the country receives about half a billion dollars of government funds. In the United Kingdom, about 98% of all abortions performed in England and Wales in 2016 were funded by the National Health Service.[1]

The World Health Organization has also aligned with countries that have liberalized and legalized abortion as can be seen from their 2012 document "Safe abortion: technical and policy guidance for health systems"[2] where it was clearly recommended that:

- Laws and policies on abortion should protect women's health and their human rights.
- Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed.

This position by the World Health Organisation reflects how acceptable abortion has become in the developed world and from this same position most of the African nations dissent.

About 80% of the African nations do not have legal abortion, not because they cannot go through the legislative steps required for it, but rather because a vast majority of the African people consider abortion to be a direct attack on human life as can be

[1] Abortion Statistics, England and Wales: 2016, page 5, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/618533/Abortion_stats_2016_commentary_with_tables.pdf.

[2] Safe abortion: technical and policy guidance for health systems, Page 9, http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1.

seen in polls like the 2013 Pew Research on Global Views on Morality that showed upwards of 80% people surveyed in the African countries were strongly against abortion.[3]

Many of the African countries are now under enormous pressure by the international community as legal abortion proponents are implying that maternal mortality will reduce in countries that remove restrictions to abortion. Yet, the Africans continue to resist because in various communities across the continent, motherhood is celebrated and considered a blessing rather than a burden by an overwhelming majority. This is also deeply rooted in the reality of the prevalent respect for human life from the earliest stages (in the womb).

The consideration of maternal health with the backdrop of the various African cultures indeed must include the wellbeing and health of pregnant women as well as their babies before, during and after birth. In order to approach and tackle the very high maternal mortality rates seen across the various African nations, one must undoubtedly do so by applying the best medical practices while respecting the cultural views and values of the people.

Even though abortion would most likely not be accepted by most African communities as a means to improving maternal health, western-based organizations and agencies like Marie Stopes International and Ipas, continue to put it forward as a most necessary means to tackle maternal mortality. This has become a setback for the African communities torn between their deeply held beliefs and the crushing and powerful ideological pressure from the more developed (donor) societies. This epitomizes the concept that some have now termed "ideological colonization." It is divisive as well as destructive and will not serve the successful reduction of maternal mortality.

According to the WHO, more than 33% of the maternal deaths in Africa is directly due to bleeding during or after delivery, almost 10% caused by infection and another 10% caused by hypertensive disorders. In addition to these, there are also many other causes of maternal deaths in Africa including Anaemia, HIV, obstructed labour, embolism and other indirect causes. According to this same data, less than 5% of maternal deaths in Africa is linked to abortion.[4]

With these well documented statistics, one would assume that most of the efforts of the well-meaning international community should be focused on tackling the main causes of maternal death. Yet the most concerted efforts are being put into the legalization of abortion in various African countries. This has become a real distraction from the major problem at hand and what is more disconcerting is that it is being funded by prominent western stakeholders. For example, the "*She Decides*" Campaign which is one of the most recent International Abortion funding initiatives, has had the support of countries like the Netherlands, Sweden, Finland, Canada, Belgium, Denmark and Norway. These nations joined forces in response to President Trump's reinstatement of

[3] Pew Research Center: Global Views on Morality, http://www.pewglobal.org/2014/04/15/global-morality/table/abortion/.

[4] Khan KS, Wojdyla D, Say L, Gülmezoglu AM, Van Look PF. "WHO analysis of causes of maternal death: a systematic review." *Lancet*. 2006 Apr 1;367(9516):1066-74.

the Mexico City Policy which defunded organizations that provide or promote abortion in their international work. These western nations raised about $190 million in March of 2017 to launch this abortion funding initiative.

These funds will not go directly to African health centres but rather to western abortion promoting organizations like Marie Stopes International and International Planned Parenthood Federation which are actively involved in lobbying parliaments in African nations to legalize abortion. The impact of such heavy and earmarked abortion funds will be detrimental to the wellbeing of mothers and their preborn babies across Africa as the emphasis will be less on maternal and neonatal care and more on abortion.

These are some of the detrimental effects of abortion that undermine the much needed maternal and newborn care in different parts of the world:

- Coerced abortions
- Weakening of marriage and family culture
- Gross-medical malpractice
- Abortion-related psychological trauma[5]
- Possibility of covering up Sexual violence and exploitation
- Illegal Abortions will continue anyway
- Death[6]

All pregnant women and their preborn babies need access to antenatal care during pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. This is the non-controversial approach that will be most welcomed by men and women alike throughout the vast continent of Africa regardless of the region, prevalent religion, tribe, clan and socioeconomic status.

[5] Coleman P.K. "Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009." *The British Journal of Psychiatry* Aug 2011, 199 (3) 180-186; DOI:10.1192/bjp.bp.110.077230.

[6] Coleman PK, Reardon DC, Calhoun BC. "Reproductive history patterns and long-term mortality rates: a Danish, population-based record linkage study." *European Journal of Public Health*, Volume 23, Issue 4, 1 August 2013, Pages 569–574.

Upholding the Sanctity of Life in a Culture of Death

Richard Weikart, Ph.D.

Though the abortion statistics are fairly well known, they are nonetheless staggering: over 58 million babies have died from abortion since *Roe v. Wade* in 1973. The world-wide statistics are even more mind-numbing: in 2010-2014 the annual international rate was 56 million abortions per year, and since 1973 there have been far more than 1 billion and probably more than 2 billion abortions in the world.[1]

However, in addition to abortion, the culture of death has continued to spiral downward, as the categories of people whose lives are not valued has expanded.[2] Since 1997 six states in the US and the nation's capital have legalized physician-assisted suicide for those with terminal illnesses. The Netherlands, Belgium, and Switzerland allow physician-assisted suicide for just about anything that can be defined as "suffering," including emotional distress. Unlike in the US, in these three European countries physicians can give the fatal injections. In the Netherlands and Belgium some physicians are euthanizing patients who are mentally incompetent and thus did not consent to their deaths. In Switzerland an individual can be euthanized upon request for just about any cause. A few years ago an Italian woman travelled to Switzerland to request death, because she noticed that her physical beauty was fading as she aged.[3]

Also, some bioethicists today are pressing for infanticide and involuntary euthanasia. In 2012 two medical ethicists, Alberto Giubilini and Francesca Minerva, published an article in *Journal of Medical Ethics* that advocated the legalization of "after-birth abortion." Ironically they used the argument that pro-lifers have been using for years: Babies after they are born are not significantly different than before they are born. Whereas pro-life advocates use this argument to show the immorality of killing babies in the womb, these bioethicists turn this argument on its head. They argue that since we already allow abortion, we should also permit infanticide.[4]

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[1] https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide, accessed 7-25-17.

[2] I discuss this issue in great depth in *The Death of Humanity: And the Case for Life* (Washington, DC: Regnery Faith, 2016).

[3] Wesley Smith, "What Happened to Switzerland" (May 2, 2014), http://www.firstthings.com/web-exclusives/2014/05/what-happened-to-Switzerland, accessed May 3, 2014.

[4] Alberto Giubilini and Francesca Minerva, "After-Birth Abortion: Why Should the Baby Live?," *Journal of Medical Ethics* (2012), http://jme.bmj.com/content/early/2012/03/01/medethics-2011-100411.full, accessed May 3, 2014.

Many Americans were dismayed at this article advocating infanticide. Two US congressmen even denounced the article on the floor of congress. The editor of the journal was astonished that the article had aroused such negative sentiments, explaining that this position was nothing new among bioethicists (as if that made it acceptable).

University of Chicago evolutionary biologist Jerry Coyne recently made this same argument in favor of infanticide on his blog. He also advanced another argument for both infanticide and euthanasia: Humans, according to him, are not special. We are just another animal species with no claim to uniqueness.[5] Coyne once stated that evolution "says that there is no special purpose for your life, because it is a naturalistic philosophy. We have no more extrinsic purpose than a squirrel or an armadillo."[6]

How did we reach the stage where prominent intellectuals do not think human life has value? When Jefferson wrote the Declaration of Independence, he stated: "We hold these truths to be self-evident: that all men are created equal, that they are endowed by their Creator with certain unalienable rights, among these are life, liberty, and the pursuit of happiness." Most of his contemporaries agreed, and these principles have prevailed through most of American history, guiding American law and jurisprudence.

However, today these truths that Jefferson considered self-evident are being challenged. Many leading intellectuals no longer believe that humans are created, that humans are equal, or that humans have inalienable rights. Those who take this view also deny that there is a fixed or objective right to life.

First, let us examine the notion that humans are not created and the bioethical implications that flow from this. In 1990 the bioethicist James Rachels published *Created from Animals: The Moral Implications of Darwinism* with Oxford University Press. Therein Rachels argues that Darwinism undermines the Judeo-Christian sanctity-of-life ethic. Rachels affirms this evolutionary devaluing of human life and thus supports the permissibility of abortion, infanticide, and euthanasia.

Rachels's position is fundamentally the same as his colleague Peter Singer, a bioethicist with an endowed chair at Princeton University. Singer divulged this same perspective to an interviewer in 2004, when he stated, "All we are doing is catching up with Darwin. He showed in the nineteenth century that we are simply animals. Humans had imagined we were a separate part of Creation, that there was some magical line between Us and Them. Darwin's theory undermined the foundations of that entire Western way of thinking about the place of our species in the universe."[7] Singer thus believes that human evolution erases any important distinctions between humans and other animals that would confer special value or sanctity to human life.

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[5] https://whyevolutionistrue.wordpress.com/2017/07/13/should-one-be-allowed-to-euthanize-severely-deformed-or-doomed-newborns/; accessed Aug. 3, 2017.

[6] Jerry Coyne, on "Conspiracy Road Trip," BBC, at http://youtu.be/Oju_lpqa6Ug, accessed October 17, 2012.

[7] Peter Singer, interview with Johann Hari, "Peter Singer—On Killing Disabled Animals, Saving Animals, and the Dangers of Superstition," at www.johannhari.com/2004/07/01/peter-singer-on-killing-disabled-babies-saving-animals-and-the-dangers-of-superstition, accessed November 18, 2009.

Singer also exemplifies the denial of human equality that is becoming more pronounced in Western culture. For instance, Singer does not think that infants have the same value as adults. In his textbook on ethics he states, "the life of a new born baby is of less value than the life of a pig, a dog, or a chimpanzee."[8] He bases this notion of human inequality on his belief that human life does not have intrinsic value. Merely being human, Singer claims, does not confer value on anyone. Rather, Singer argues that value only comes to those having certain capacities (whether they are human or not). Chief among these value-granting characteristics are rationality and self-consciousness. Those with a certain level of rationality are "persons," according to Singer, and those not meeting the grade are "non-persons," who thus have no rights, including the right to life.

This "personhood theory" of Singer and other bioethicists suffers from many problems. When I debated Singer on a radio show about whether or not human life has intrinsic value (Singer, of course, argued the negative position), I asked him why he chose rationality rather than some other traits. I was astonished that he didn't offer an answer, but suggested this point was up for discussion.[9] Indeed, it seems apparent to me that Singer has no grounds in his worldview for valuing rationality, so choosing rationality as the criterion for achieving "personhood" is rather arbitrary. (Really, while logically arbitrary, it is not personally arbitrary, since Singer is an intellectual and personally values rationality, even though I do not think his worldview provides a reason for him to value it).

Not only is the criterion for attaining "personhood" arbitrary, but the minimal level of rationality or self-consciousness required to be considered a "person" by these bioethicists is also arbitrary. Singer seems sure that a newborn infant has not attained a high enough level to be considered a person, but he admits that he doesn't know when a human does attain the requisite level. In any case, many bioethicists besides Singer have adopted this "personhood theory," and often they use it to justify abortion, since they do not think that a fetus is a full-fledged person.

While Singer and many other intellectuals take a rationalist approach to denying human equality, some intellectuals follow Friedrich Nietzsche by adopting an irrationalist approach. Nietzsche, the founding father of existentialism and the darling of most postmodernists, exerts a powerful influence in academe today, especially in the humanities. Nietzsche had utter contempt for the masses of humanity, and preached that an intellectual elite should exert their "will to power" to become the Overman or Superman (*Übermensch*). According to Nietzsche, this intellectual aristocracy (not to be confused with the landed aristocracy) should dominate and oppress the weaker people, whom Nietzsche derisively called "the herd." With his power-to-the-strong philosophy Nietzsche at times overtly endorsed killing people with disabilities.[10]

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[8] Peter Singer, *Practical Ethics* (Cambridge: Cambridge University Press, 1979), 76, 122-23, 125.

[9] https://www.premierchristianradio.com/Shows/Saturday/Unbelievable/Episodes/Unbelievable-Is-human-life-intrinsically-valuable-Peter-Singer-Richard-Weikart-Susan-Blackmore

[10] Weikart, *Death of Humanity*, 189-93.

Besides denying that some humans are persons deserving of rights, some intellectuals have denied that humans have any rights whatsoever. One early nineteenth-century figure denying human rights was Jeremy Bentham, the founding father of utilitarianism. Utilitarianism, which bases all morality on what brings the "greatest happiness for the greatest number," is very influential today (Singer, among many others, embraces utilitarianism). Bentham defined happiness as whatever brings pleasure and reduces pain. Deriving morality and public policy through the utilitarian pleasure-pain principle meant that every precept would be judged by its consequences, not by some fixed standards. Based on this view of morality, Bentham derided the notion of human rights as nonsense and famously called imprescriptible human rights "nonsense upon stilts."[11]

In his private papers—but not publicly—Bentham spelled out some of the more controversial consequences of his philosophy. He denied, for instance, that murder violated some inalienable human rights of the victim. Nonetheless, he insisted that allowing murder would breed fear among multitudes in society, and this would bring more pain than pleasure. Thus Bentham considered murder—at least in most cases—morally wrong. However, he thought that one form of murder—infanticide—was morally acceptable. Infants, he reasoned, would not know enough to fear being killed, so as long as they were killed painlessly, he saw nothing wrong with it.[12]

Nietzsche's philosophy is poles apart from Bentham's, but one feature they shared in common was their rejection of human rights (based on their common rejection of Christianity). Nietzsche rejected the notion that any kind of objective morality or human rights exist. He called for his intellectual elite Overmen to live "beyond good and evil." He scoffed at Christian values, such as compassion and pity, and he scorned those who helped the poor and weak in society. Life, he taught, is all about exploiting and overpowering other people, of trampling on the supposed rights they may think they have. He denied that anyone has a right to life, stating, "The great majority of men have no right to existence, but are a misfortune to higher men."[13] Since Nietzsche thus thought the majority of humans have no right to life, it is no wonder he explicitly advocated infanticide for children with disabilities.

One of Nietzsche's French disciples, Michel Foucault, is probably the most influential philosopher of the late twentieth century. His postmodernist philosophy is being taught widely in American universities, especially in the humanities. Foucault, like his mentor Nietzsche, taught that truth is constructed, not discovered. This includes moral truths and human rights, which he considered human creations, mere inventions of the human mind, rather than part of objective reality.

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[11] Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation*, ed. J. H. Burns and H. L. A. Hart (London: University of London, The Athlone Press, 1970), 100.

[12] John Dinwiddy, *Bentham* (Oxford: Oxford University Press, 1989), 112.

[13] Nietzsche, *Will to Power,* part 872, quoted in Jean Gayon, "Nietzsche and Darwin," in *Biology and the Foundation of Ethics*, ed. Jane Maienschein and Michael Ruse (Cambridge: Cambridge University Press, 1999), 183.

Foucault hewed true to his amoralist philosophy when he debated the famous linguist Noam Chomsky in 1971 on human nature. Politically both Chomsky and Foucault are radical leftists, and both approve of the revolutionary conquest of power by the underclasses. However, Foucault objected to Chomsky's position that the revolutionaries should restore and promote justice after attaining power. Because he did not believe in the existence of justice, Foucault favored revolutionary violence and showed no concern for the welfare of those suppressed in the revolution. Foucault stated in that debate: "When the proletariat takes power, it may be quite possible that the proletariat will exert towards the classes over which it has just triumphed, a violent, dictatorial, and even bloody power. I can't see what objection one could make to this."[14] (Contra Foucault, I can think of quite a few objections to violent, dictatorial power). Reflecting on the debate afterward, Chomsky stated, "I felt like I was talking to someone who didn't inhabit the same moral universe."[15]

What implications does Foucault's amoral philosophy have for bioethics? Last year I wrote an article about him entitled, "Why Do Intellectuals Venerate This Sado-Masochistic, Suicidal Drug Addict?"[16] Sado-masochism, suicide, and drug use are not some personal quirks incidental to Foucault's philosophy. Rather they are intertwined in his philosophy. For instance, he often assigned his students to read the Marquis de Sade's perverted writings endorsing the whole-hearted pursuit of personal pleasure, even if it involved torturing other humans. Concerning suicide, not only did Foucault attempt suicide several times as a young man, but he promoted suicide. Near the close of his life he stated that we need to "teach people that there is not a piece of conduct more beautiful or, consequently, more worthy of careful thought than suicide. One should work on one's suicide throughout one's life."[17] He once stated in an interview, "If I won a few billion francs in the national lottery, I'd set up an institute where people who wanted to die could come and spend a weekend, a week or a month, enjoying themselves as far as possible, perhaps with the help of drugs, and then disappear, as if by obliteration."[18] Foucault overtly acknowledged that his views lead to the "death of man."[19]

As we have already seen, many secular philosophies have undermined the right to life. Beginning in the Enlightenment, this has had a profound impact on debates surrounding the value of human life. The first major debate over these issues to erupt during the Enlightenment was about the morality of suicide. Before the Enlighten-

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[14] Noam Chomsky and Michel Foucault, *The Chomsky-Foucault Debate: On Human Nature* (New York: The New Press, 2006), 47-52.

[15] James Miller, *The Passion of Michel Foucault* (New York: Simon and Schuster, 1993), 203.

[16] Richard Weikart, "Why Do Intellectuals Venerate This Sado-Masochistic Suicidal Drug Addict?, *The Stream*, September 13, 2016, at https://stream.org/foucault-intellectuals-venerate-sado-masochistic-suicidal-drug-addict/.

[17] Quoted in James Miller, *The Passion of Michel Foucault* (New York: Simon and Schuster, 1993), 351.

[18] Michel Foucault, *Politics, Philosophy, Culture: Interviews and Other Writings*, 1977-1984, trans. Alan Sheridan et al, ed. Lawrence D. Dritzman (New York: Routledge, 1988), 176.

[19] Quoted in Didier Eribon, *Michel Foucault*, trans. Betsy Wing (Cambridge, MA: Harvard University Press, 1991), 157.

ment suicide was almost universally rejected in Western culture. However during the Enlightenment, some thinkers, such as the famous British philosopher David Hume, argued that suicide was permissible. In his essay, "On Suicide," which was published posthumously in 1777, Hume divulged the dehumanizing thrust of his philosophy, when he stated, "But the life of a man is of no greater importance to the universe than that of an oyster."[20] Suicide, then, is no big deal.

In the late nineteenth century a new debate about the value of human life emerged when some began arguing for euthanasia. The term euthanasia, which literally means "good death," had previously meant trying to relieve pain and suffering for those nearing death. However, the term was redefined in the late nineteenth century by a new movement that favored taking active measures to end the lives of those who were either suffering or disabled. While many early euthanasia proponents supported assisted suicide or voluntary euthanasia, some began supporting killing disabled infants and sometimes adults. Nazi Germany became the most radical promoter of euthanasia, when under the cover of World War II Hitler introduced a program to kill people with disabilities. The Nazi euthanasia program killed over 200,000 disabled Germans and untold thousands more in Nazi-occupied territories.

In the twentieth century abortion became one of the hottest controversies relating to the right to life. At the beginning of the century abortion was almost universally outlawed, but over the course of time—especially during the so-called Sexual Revolution of the 1960s and 1970s—this changed, and by the end of the century abortion was legal in most countries of the world.

What influence do these secularizing tendencies have on human rights, including the right to life? Recently the sociologist John Evans in *What Is a Human? What the Answers Mean for Human Rights* conducted a study to see if people's worldview affects their support for human rights. He wanted to see if the charge that secularism undermines human rights has any validity. He discusses my own earlier book, *From Darwin to Hitler: Evolutionary Ethics, Eugenics, and Racism in Germany*, as one example among others that argues that secularism does devalue human life.[21]

In his study Evans identifies three main views (held by Americans) of what it means to be human: 1) the theological view, which sees humans as being created in the image of God; 2) the biological view, which sees humans as determined by their biological traits that arose through evolutionary processes; and 3) the philosophical view, which defines humanity by the traits they possess (an example of this third view is Peter Singer). Evans is a secularist who is not sympathetic with the Christian worldview, but he candidly admits that his surveys showed that people embracing the theological worldview have greater respect for human rights than those upholding the other two positions. This provides powerful support for my contention that secularism

[20] David Hume, "On Suicide," in *Life, Death and Meaning: Key Philosophical Readings on the Big Questions*, ed. David Benatar (Lanham, MD: Rowman and Littlefield Publishers, 2004), 291-92.

[21] John Evans in *What Is a Human? What the Answers Mean for Human Rights* (Oxford University Press, 2016).

undermines human rights, a point I develop at length in my recent book, *The Death of Humanity: And the Case for Life*.

In the face of these secular dehumanizing tendencies and the culture of death it has spawned, we need to reassert the position that human life has value, that human lives are equal in value, and that humans have inalienable rights. It may seem daunting or downright discouraging at times, especially when we hear about the many negative cultural trends. However, my objective in this essay is not to discourage you by exposing the problems, but to encourage you to engage in this noble cause of promoting a culture of life, so we can change the hearts and minds of our society. Many righteous causes, such as the abolition of slavery or the Civil Rights Movement, faced seemingly insurmountable obstacles, but heroic individuals resisted the rampant dehumanization of African-Americans, and these movements ultimately gained considerable success.

So, what can we do? First and foremost, use every opportunity to speak up for the weak and vulnerable. This includes the unborn, but also those who are terminally ill or disabled. We need to insist that they share in the equal rights we enjoy.

Second, promote objective morality and human rights. Many secularists will insist that all morality is relative, but it seems to me that most moral relativists are not really moral relativists at all. Instead, they try to use moral relativism as a weapon to debunk and destroy moral standards they do not like. However, even while they undermine traditional morality, they sneak in their own moral standards that they consider inviolable. Just try challenging some moral standard or value they hold dear, and you will suddenly discover that anyone rejecting their perspective is absolutely immoral and evil.

Third, we need to exalt and exemplify love over selfishness. Our society is characterized by the selfish pursuit of pleasure, which underpins the Sexual Revolution and helps drive the abortion lobby. Defending abortion is often a way to protect the untrammeled pursuit of sexual pleasure, as well as trying to avoid the sacrifices and self-denial necessary to raise a child. We need to promote and exemplify a willingness to sacrifice for others, rather than pursuing our own selfish pleasures.

Fourth, we need to extend that love toward women facing unexpected pregnancies. Many crisis pregnancy centers already do this and save untold babies from destruction by providing loving support for pregnant women, who may or may not have much support from the father of their child, their families, or friends.

Finally, despite the countervailing indications, be assured that ultimately love and truth will prevail. However, even if we do not see any far-reaching results, we still need to be faithful and exercise as much influence as we can. Every single life saved is worth our effort.

The Menstrual Cycle as a Vital Sign: The Use of Naprotechnology® in the Evaluation and Management of Abnormal Vaginal Bleeding and PCOS in the Adolescent

Shirley González, M.D.

The topic of how the menstrual cycle is a vital sign which could signal pathophysiologic process has received considerable attention in the past decade. The current recommendations of various academic groups will be discussed as well as the Fertility™ Care method of charting and the Naprotechnology approach to evaluating abnormalities of the menstrual cycle. Two clinical scenarios seen in adolescent medicine, PCOS and AUB, will be analyzed looking at the pathophysiology of these clinical scenarios and their management. The approach will be one that conducts an evaluation to try to find the underlying problem and aims to restore the normal physiology of the menstrual cycle.

The American Academy of Pediatrics, the American College of Obstetrics and Gynecology and the New York Academy of Sciences have published academic statements during the past ten years emphasizing the need for providers to teach patients how to chart and the important clinical ramifications of using this charting as a vital sign. In 2006 the American Academy of Pediatrics published in the *Pediatrics Journal* a recommendation titled: "Menstruation in Girls and Adolescents: Using the Menstrual Sign as a Vital Sign."[1] In 2015, the American College of Obstetrics and Gynecology published a Committee Opinion emphasizing the need to teach women the charting of their menses and the important pathophysiologic process that could be detected with the charting.[2] In 2008, the New York Academy of Sciences published a book on the menstrual cycle

[1] American Academy of Pediatrics, Committee on Adolescence, American College of Obstetricians and Committee on Adolescent Healthcare. Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign. *Pediatrics*. 2006;118(5):2245-2250.

[2] Menstruation in girls and adolescents: using the menstrual cycle as a vital sign. Committee Opinion No. 651. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2015;126:e143–6.

which included a chapter titled: "The Menstrual Cycle: A Biological Marker of General Health in Adolescents: Why should the Menstrual Cycle be Considered a Vital Sign?"[3] Indeed, prospective charting of the menstrual bleeding patterns and other biomarkers create a visual picture which may signal the provider that pathophysiologic conditions may be present and may aid in the clinical management of these ones.

Before proceeding to an in depth discussion of the charting of the menstrual cycle, it is imperative that a discussion of the ovarian events, hormonal events and changes to endometrial lining be presented. The plasma concentrations of estrogen, progesterone, luteinizing hormone (LH), and follicle-stimulating hormone (FSH) during the human menstrual cycle correspond to proliferative and secretory changes in the endometrium and to follicular development and ovulation.[4] Estrogen is the predominant hormone pre-ovulatory (also referred to as pre-Peak phase when looking at the charts) and progesterone is the main hormone post-ovulatory) (post-Peak phase). Adequate levels of FSH and LH are necessary for the cycle to proceed in a physiologic manner. The endometrium goes through a proliferative phase in response to estrogen and through a secretory phase in response to progesterone. If progesterone levels are not adequate, the sloughing of the endometrial lining may follow an abnormal unpredictable pattern. If estrogen is not opposed by progesterone the lining may undergo abnormal changes.

Charting of the menstrual cycles using the Fertility™ Care system generally follows this pattern: menses, dry days, mucorrhea, which is then followed by the dry days. The pre-Peak phase starts with the first day of the menses and ends on the Peak day. The post-Peak phase starts on the day after the Peak day and ends on the day prior to the next menses. There is a correlation between the charting of the mucorrhea and the hormonal events of rise of FSH, estrogen, LH and progesterone.[5] There is also a correlation between the charting of the mucorrhea and the development of the follicle followed by ovulation.[6] Dr. Odeblad conducted extensive research on the mucorrhea, the cervical crypts and the estrogen receptors found on the cells of these crypts which produce mucus in response to estrogen.

Fertility™ Care is a system of menstrual charting which is based on biomarkers which were interpreted (translated) through an orderly clinical and scientific investigation. Biomarkers include bleeding, dryness, and mucorrhea. The system was developed using a clinically useful understanding of the menstrual and fertility cycles. Naprotechnology® is the term given to the medical applications of charting the menstrual cycle

[3] Gordon CM, Welt C, Rebar RW, Hillard PJA, Matzuk MM, Nelson LM, eds. The Menstrual Cycle and Adolescent Health. *Annals of the New York Academy of Sciences*. 2008;1135:1-308.

[4] Molina PE. *Endocrine Physiology*, 4e; 2013 Available at: http://accessmedicine.mhmedical.com/ViewLarge.aspx?figid=42541475 Accessed: June 02, 2017.

[5] Faccioli G, Cortesi S, Calderoni P. Structure of Human Cervical Mucus, Correlation with Plasma Ovarian Hormone Levels. *Acta Eur Fertil*. 1983;14:41-50.

[6] Leader A, Wiseman D, Tayler PJ. The Prediction of Ovulation: A Comparison of the Basal Body Temperature Graph, Cervical Mucus Score and Real Time Pelvic Ultrasonograph. *Fertil Steril*. 1985;43:385-388.

working in cooperation with this one using medications and/or surgery. It represents a new women's health science that cooperates with the menstrual cycle.

Various problem solving and case management principles are used in the practice of Naprotechnology®. Getting a detailed history and obtaining a good physical exam is followed by studying the menstrual chart analyzing the biological markers the patient charts for the provider. Appropriate laboratory and sonographic evaluations will follow using targeted hormone profile to investigate for underlying problems. Therapy is then implemented with the goal of restoring normality of menstrual cycles. One needs to look globally at the chart especifically looking at the cycle length and regularity, the length of the pre and post-Peak phase, the occurrence of the Peak day, the intensity of the mucus flow (mucus cycle score: 9.1-16 Regular, 7.6-9 Intermediate Regular), occurrence of continuous discharges and their characteristics, and last, the characteristics of the bleeding pattern.

Before proceeding to the various pathologic conditions one may see in adolescents, a review of the current terminology used in adolescents is needed. An international meeting was organized to make the case for describing the menstrual bleeding in terms of cycle regularity, frequency, duration of flow and volume with the goal of achieving international agreement on terminologies and definitions used to describe abnormalities of menstrual bleeding.[7] In terms of frequency, menses may be characterized as frequent, normal or infrequent with normal in adolescents being 21-45 days. Regularity is described as absent, regular or irregular with 90 days being the upper limit of normal. Duration of flow may be prolonged, normal or shortened with normal considered to be 2-7 days. Volume of blood loss (ml) may be characterized as heavy, normal, or light with > 80 ml associated with anemia and normal being around 30 ml.

The first pathophysiologic condition to be discussed will be PCOS. Three criteria have been used to diagnose PCOS. All three criteria assume exclusion of other diagnoses that may replicate symptoms of PCOS such as nonclassical congenital adrenal hyperplasia.[8] As of 2011, there were three sets of criteria proposed to diagnose PCOS in adult women: the 1990 National Institute of Health (NIH) conference, the 2003 ASRM/ESHRE Rotterdam Consensus Criteria and the 2006 Androgen Excess Society (now the Androgen Excess and PCOS Society) guideline. The 1990 NIH criteria defined PCOS as a combination of hyperandrogenism (clinical or biochemical) and oligoanovulation. The 2003 Rotterdam conference expanded the diagnostic criteria requiring two of the following three criteria: oligomenorrhea and/or anovulation, clinical or biochemical signs of hyperandrogenism and PCO by transvaginal ultrasound.The Androgen Excess Society saw a need to define PCOS as a disorder with primary hyperandrogenism. Their criteria include: hyperandrogenism (hirsutism and/or hyperandrogenemia) and ovarian dysfunction (oligoanovulation and/or PCO on ultrasound). Under the Androgen

[7] Paula J. Adams Hillard. Menstruation in Adolescents: What Do We Know? and What Do We Do with the Information? *J Pediatr Adol Gynec*. 2014;27(6):309–319.

[8] O'brien RF, Emans SJ. Polycystic Ovarian Syndrome in Adolescents Mini-Review. *J Pediatr Adol Gynec*. 2008;21(3):119-128.

Excess Society criteria, irregular menses and PCO morphology alone are not sufficient for diagnosis. In 2011, the NIH published updated information. They recommend: 1-Creating a new name that reflects the complex metabolic, hypothalamic, pituitary, ovarian, and adrenal interactions seen in PCOS; 2-Maintaining Rotterdam criteria with reporting of phenotype; 3-Improving methods and criteria used to assess androgen excess, ovulatory dysfunction, and PCO morphology; 4-Conducting more research.[9] As adolescents may experience transient infrequent menses and mild hyperandrogenemia in early adolescence as well as PCO morphology and infrequent menses some have asked for alternative diagnostic criteria in adolescents using infrequent or absent menses two years post menarche, clinical hyperandrogenism, hyperandrogenemia, insulin resistance, hyperinsulinemia, and polycystic ovaries as diagnostic criteria.

Pathophysiology of PCOS is characterized by ovarian enzyme dysregulation which involves the theca and the granulosa cells which surround the oocyte in the secondary stage of development.[10] An increased GnRH activity may lead to aberration in LH secretion. LH stimulates the theca cells in the ovaries to produce androstenedione and testosterone. Testosterone is then converted to estradiol in the granulosa cell. Insulin also stimulates the theca cells and inhibits SHBG production. It is unknown whether hypothalamic dysfunction is the primary cause of PCOS or if it occurs in response to abnormal steroid feedback. A review of the metabolic pathways for the ovarian biogenesis of estrogen and progesterone indicates that androstenedione can be converted to estrone and testosterone, both of which can then be converted to estradiol.[11] The pathogenesis of the various clinical manifestations of the Polycystic Ovary Syndrome involves an increase in LH and insulin, a decrease in SHBG and a hyperstimulation of the Theca cells by Insulin and LH.[12] The ovary has insulin receptors. Insulin stimulates ovarian estrogen and androgen secretion. It is thought that insulin resistance leads to anovulation as normal menstruation resumes in many patients who are on insulin sensitizers. These medications lead to lower insulin levels, higher SHBG levels and therefore less circulating androgen levels. The decrease in SHBG leads to an increase in free testosterone which is thought to lead to inhibition of follicular maturation as well as hirsutism and an increase in free estradiol levels which in turn leads to increase in LH secretion.

As mentioned at the beginning of this discussion, PCOS is a diagnosis of exclusion. At least nine disorders need to be considered. These conditions and the respective laboratory tests and values used to diagnose them are: Hypothalamic Amenorrhea (low FSH), Prolactinoma (high Prolactin), Hyperthyroidism (low TSH), Hypothyroidism

[9] National Institute of Health, Evidence-based Methodology Workshop on Polycystic Ovary Syndrome, December 3-5, 2012. Executive Summary.

[10] Mescher AL. *Junqueira's Basic Histology,* 14e; 2016 Available at: http://mhmedical.com/ Accessed: June 10, 2017.

[11] Adapted from: Loughlin T, Cutler GB: Pro-Opiomelanocortin and Regulation of Adrenal Androgen, In: Lobo BA (Ed). *Seminars in Reproductive Endocrinology*, 5:153-159, 1987.

[12] Hammer GD, McPhee SJ. *Pathophysiology of Disease: An Introduction to Clinical Medicine*, 7e; 2013 Available at: http://accessmedicine.mhmedical.com/ViewLarge.aspx?figid=53633992 Accessed: June 10, 2017.

(high TSH), Late Onset Congenital Adrenal Hyperplasia (high 17-hydroxyprogesterone >800 ng/dL-if 200-800 ng/dL refer to Pediatric Endocrinologist for provocative test), Premature Ovarian Failure (high FSH), Cushing's Syndrome (high Cortisol), Ovarian Tumor (very high Testosterone > 150 mg/dL), Adrenal Tumor (very high DHEAS > 500 mcg/dL, some use 700 mcg/dL).

Various risk factors have been associated with PCOS. Exposure to androgens in utero may contribute to development of PCOS. Prenatal testosterone exposure in animal models results in many characteristics of this syndrome.[13] Other risk factors include: fetal growth restriction, being large for gestational age (LGA), excessive postnatal catch up growth, ethnicity (Hispanic women with polycystic ovarian syndrome have the most severe phenotype, both in terms of hyperandrogenism and metabolic criteria),[14] premature pubarche, and obesity with acanthosis nigricans. The process of establishing a diagnosis of PCOS includes: Obtaining a history especifically looking at birth history, age of menarche, menstrual cycle pattern, list of non prescription and prescription medications; conducting a physical exam looking for obesity, acanthosis nigricans, hirsutism and acne among other physical findings; obtaining appropriate laboratory tests; obtaining a pelvic and adrenal ultrasound when appropriate; and reviewing the menstrual chart. Regarding hirsutism, some use the Hirsutism scoring scale of Ferriman and Gallwey.[15] The nine body areas that have androgen-sensitive areas are graded from 0 (no terminal hair) to 4 (frankly virile) to obtain a total score. A normal hirsutism score is <8. This may be useful when evaluating effects of treatment. In Acanthosis Nigricans, insulin stimulates keratinocyte and dermal fibroblast growth. One may see hyperpigmented plaques on a velvet-like surface on the neck.[16] It may be seen in other body folds: neck, armpits, groin, navel, and forehead. Acanthosis nigricans is also seen in genetic syndromes and in gastrointestinal tract malignancies (adenocarcinoma of stomach, pancreas).

Laboratory evaluation may include: LH, FSH, Prolactin, Thyroid Function Tests, 17-Hydroxyprogesterone, Free Testosterone, Testosterone, DHEAS, Progesterone, ALT, SHBG, HgA1C, OGTT and Chromosome analysis. Ultrasound of the ovaries my reveal a population of follicles which has undergone disordered folliculogenesis from elevated LH and Insulin levels. Follicular development is arrested. Various sonographic criteria for multifollicular ovarian morphology have been proposed. Of note, 30% of women with regular cycles between ages of 25-30 years have morphological characteristics consistent with polycystic ovaries and 30% of women with PCOS do not have cystic

[13] Roland AV, Nunemaker CS, Keller SR, Moenter SM. Prenatal Androgen Exposure Programs Metabolic Dysfunction in Female Mice. *J Endocrinol*. 2010;207(2):213-23.

[14] Engmann L, Jin S, Sun F, Legro RS, Polotsky AJ, Hansen KR, et al. Racial and ethnic differences in the polycystic ovary syndrome metabolic phenotype. *Am J Obstet Gynecol*. 2017;216(5):493.e1–493.e13.

[15] Kasper D, Fauci A, Hauser S, Longo D, Jameson J, Loscalzo J. *Harrison's Principles of Internal Medicine*, 19e; 2015 Available at: http://accessmedicine.mhmedical.com/ViewLarge.aspx?figid=98706532 Accessed: April 23, 2017.

[16] Kasper D, Fauci A, Hauser S, Longo D, Jameson J, Loscalzo J. *Harrison's Principles of Internal Medicine*, 19e; 2015 Available at: http://accessmedicine.mhmedical.com/ViewLarge.aspx?figid=98707255 Accessed: May 29, 2017.

ovaries. Also, the morphogenesis of PCO is not unique to PCOS. It may be seen in late onset congenital adrenal hyperplasia, HIV, and epilepsy.

Various comorbidities may be associated with PCOS. In terms of prediabetes and Type 2 diabetes mellitus, it has been found that 30% of women with PCOS may have IGT (impaired glucose tolerance) and 7% may have diabetes.[17] Regarding conversion rate, it has been shown that 2% convert to diabetes mellitus per year.[18] It is interested to note that even after adjusting for BMI, women with PCOS remain more likely to have diabetes.[19] Some have found intrinsic abnormalities at the receptor/post receptor level independent of obesity.[20] Other comorbidities include cardiovascular abnormalities and dyslipidemia.

When discussing the management of PCOS, one needs to look at the acute management as well as the chronic management. Acute management involves counseling regarding weight loss, establishing regular cycles and monitoring for and treating prediabetes and diabetes. Achieving 10% weight loss may restore normality of menstrual cycle. Thus it is important that adequate lifestyle counseling be given to address the importance of making healthy nutritional choices and increasing the level of physical activity. Establishing regular cycles may be achieved by treating unopposed estrogen with micronized progesterone.[21] Micronized progesterone may be started at a dose of 200-400 mg 10-12 days. Alternative, IM progesterone may be given at a dose of 200 mg IM every other day for 4-5 days on a cyclic basis.Treatment goal should aim for 4-6 menstrual cycles/year. If patient is found to have prediabetes/insulin resistance, metformin can be started on patients who fail intensive lifestyle interventions. This will help establish normality of menstrual cycle and will improve insulin resistance. Metformin suppresses gluconeogenesis, may increase GLP-1 secretion, may antagonize glucagon, and increases insulin sensitivity.

The Pediatric Endocrinology Society Guidelines state:

> Reducing insulin resistance may also improve the signs and symptoms of PCOS. At least 150 minutes of physical activity that raises the heart rate every week decreases insulin resistance. A healthy diet without sweet drinks like sodas and many concentrated carbohydrates and processed foods will also decrease insulin resistance as a result of some weight loss. Metformin is a medication that may be used to treat PCOS. It helps reduce insulin resistance, and can be associated with a small amount of weight

[17] Legro RS, Kunselman AR, Dodson WC, Dunaif, A. Prevalance and Predictors of Risk for Type 2 Diabetes Mellitus and Impaired Glucose Tolerance in Polycystic Ovary Syndrome: A Prospective, Controlled Study of 254 Affected Women. *J Clin Endocrinol Metab*. 1999;84(1):165-169.

[18] Legro RS, Gnatuk CL, Kunselman AR, Dunaif A. Changes in Glucose Tolerance over Time in Women with Polycystic Ovary Syndrome: A Controlled Study. *J Clin Endocrinol Metab*. 2005;90(6):3236-3242.

[19] Lo JC, Feigenbaum SL, Yang J, Pressman AR, Selby JV, Go AS. Epidemiology and Adverse Cardiovascular Risk Profile of Diagnosed Polycistic Ovary Syndrome. *J Clin Endocrinol Metab*. 2006; 91(4):1357-1363.

[20] Dunaif A, Segal KR, Shelley DR, Green G, Dobrjansky A, Licholai T. Evidence for Distinctive and Intrinsic Defects in Insulin Action in Polycystic Ovary Syndrome. *Diabetes*. 1992;41:1257-1266.

[21] Lignières B. Oral Micronized Progesterone. *Clin Ther.* 1999;21(1):41-60.

loss. It has not yet been approved by the FDA (Federal Drug Administration) to be used for PCOS but it is usually safe and often helps.[22]

Acanthosis Nigricans may improve with weight reduction, lac-hydrin, tretinoin, and metformin. Acne responds to topical retinoid monotherapy, topical antimicrobial therapy, benzoyl peroxide, and antibiotics. Topical retinoids regulate follicular keratinocytes, normalize their desquamation, and have direct anti-inflammatory properties. Minocycline/Doxycycline may be added if no improvement is noted with topical treatment. Hirsutism may improve with Spironolactone, which is an androgen receptor binding agent, at doses of 50-100 mg bid.[23] Spironolactone is an aldosterone antagonist which possesses antiandrogenic properties and exerts its peripheral antiandrogenic effects in the hair follicle by competing for androgen receptors and displacing dihydrotestosterone at both nuclear and cytosol receptors. It also affects hair conversion from vellus to terminal by its direct inhibition of 5 alpha reductase and lowers testosterone levels by inhibiting the cytochrome P450 monooxygenases that are required for biosynthesis of androgens in gonadal and adrenal steroid-producing cells. Its anti-mineralocorticoid and diuretic properties are rarely prominent in young women but conducting periodic screening of potassium level to identify hyperkalemia may be recommended. Metformin may decrease androgen levels and may be used in combination with spironolactone.

Chronic management of PCOS needs to include assessment of cardiovascular health, including monitoring for and treatment of hypertension and dyslipidemia. It also includes assessment of risk of developing endometrial carcinoma and management of subfertility. Patients with PCOS have been found to have decreased compliance and increased stiffness of the common carotid artery (CCA) and the internal carotid artery (ICA) which suggests an increased risk of CAD/stroke.[24] The extent to which PCOS impacts on future cardiovascular events during older age is to be determined. PCOS does serve as a cardiovascular clinical marker. Patients with PCOS may be at increased risk of developing endometrial carcinoma if they have experienced chronic unopposed estrogen exposure and this has not been addressed in the past. A biopsy for endometrial assessment may be recommended if there has been prolonged irregular bleeding and IMB-intermenstrual bleeding. Ovarian wedge resection has shown to improve rates of fertility in this population.

In the future, providers may be using AMH (Anti Mullerian Hormone) to help establish diagnosis. AMH is produced within the granulosa cells of developing follicles and level correlates with the number of antral follicles. Also, Adiponectin may serve as a biological marker as the levels seem to be significantly lower in the daughters of

[22] https://www.pedsendo.org/patients_families/Educational_Materials/index.cfm. Accessed August 13, 2017.

[23] Ganie MA, Khurana ML, Gulati EM, Dwivedi SN, Ammini AC. Comparison of Efficacy of Spironolactone with Metformin in the Managemet of Polycystic Ovary Syndrome: An Open-Labeled Study. *J Clin Endocrinol Metab*. 2004; 89:2756-2762.

[24] Lakhani K, Seifalian AM, Hardiman P. Impaired Carotid Viscoelastic Properties in Women with Polycystic Ovaries. *Circulation*. 2012; 106:81-85.

women who have PCOS before the onset of hyperandrogenism and may be an earlier marker of metabolic derangement in adolescent girls.

Fertility™ Care charting of the menstrual cycle of women with PCOS may reveal the following (Mean, range): Cycle length (45, 29-133) days; Post-peak phase (15, 11-25) days; Mucus Cycle Score (MS) (4.82, 0-10.7).[25]

The second pathophysiologic condition that will be presented is Abnormal Uterine Bleeding (AUB) in the adolescent patient. AUB can be categorized as Heavy Menstrual Bleeding (HMB) and Intermenstrual Bleeding (IMB).[26] Discarded terms include dysfunctional uterine bleeding, menorrhagia, functional uterine bleeding, hypermenorrhea, hypomenorrhea, menometrorrhagia, metrorrhagia, oligomenorrhea, polymenorrhea, and uterine hemorrhage. Frequency of menstrual cycles in adolescence can range from 21 to up to 45 days. Menses can last 3-7 days with > 80 ml of blood loss and changing pads/tampons every 1-2 hrs or more frequently considered abnormal. The FIGO classification of causes of abnormal uterine bleeding in the reproductive years was established with the goal of creating a basic classification system. The basic system comprises four categories that are defined by visually objective structural criteria (PALM: Polyp, Adenomyosis, Leiomyoma, and Malignancy or hyperplasia); and four (COEIN) that are unrelated to structural anomalies (Coagulopathy, Ovulatory Dysfunction, Endometrial etiologies, Iatrogenic causes, Not yet classified).[27]

A foundational point to understanding the pathophysiology involved in AUB and the management of this one is understanding the vascular supply to the uterus, the anatomy of the endometrium, the physiologic effects of progesterone on the lining of the endometrium and the steps that lead to a normal menses.[28] The vasculature supplying blood to the uterus includes: uterine, arcuate, radial, basal and spiral arteries. The endometrium consists of two layers, the functionalis and the basalis. The basalis layer, in direct contact with the myometrium, is beneath the functionalis.The basalis layer is less hormonally responsive and serves as a reservoir for regeneration of the functionalis layer following menses. The functionalis layer undergoes dramatic changes throughout the menstrual cycle and ultimately sloughs during menstruation. Blood reaches the uterus via the uterine and ovarian arteries. The arcuate arteries arise from these and supply the myometrium. These branch into the radial arteries, which extend toward the endometrium at right angles from the arcuate arteries. The radial arteries then divide to create the basal and spiral arteries.

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[25] Hilgers, TW. *The Medical & Surgical Practice of Naprotechnology*. 1st ed. Omaha, NE: Pope Paul VI Institute Press; 2004.

[26] The American College of Obstetricians and Gynecologists. *Practice Bulletin*, Clinical Management Guidelines for Obstetriticians-Gynecologists: Diagnosis of Abnormal Uterine Bleeding in Reproductive-Aged Women. 2012;120(1):197-206.

[27] Malcolm G. Munro, Hilary O.D. Critchley, Ian S. Fraser.The FIGO classification of causes of abnormal uterine bleeding in the reproductive years. *Fertil Steril*. 2011;95(7):2204–2208.e3.

[28] Hoffman BL, Schorge JO, Bradshaw KD, Halvorson LM, Schaffer JI, Corton MM. *Williams Gynecology*, 3e; 2016 Available at: http://accessmedicine.mhmedical.com/content.aspx?bookid=1758&sectionid=118168196&jumpsectionID=118168225 Accessed: June 02, 2017.

Progesterone stabilizes the endometrium and blocks endometrial stromal cell production of matrix metalloproteinase (MMP's). The latter degrade the extravascular and stromal matrix. Progesterone stimulates stromal cell Tissue Factor production- a key factor in the extrinsic coagulation pathway. Progesterone stimulates Plasminogen Activator Inhibitor-1, which blocks fibrinolysis, thus stabilizing clots. At the end of each menstrual cycle, progesterone levels drop and MMPs are released. These enzymes break down the stroma and vascular architecture of the functionalis layer. Subsequent bleeding and sloughing of this layer constitute menstruation. Initially, platelet aggregation and thrombi control blood loss. In addition, the remaining endometrial arteries, under the influence of mediators, vasoconstrict to limit further bleeding.

Conditions which could present as AUB include: Premature Ovarian Failure, sexually transmitted diseases, bleeding disorders (Von Willebrand Disease, Platelet aggregation disorder/coagulation disorder; primary genetic defects of platelet receptor-Bernard-Soulier Syndrome, Glanzmann Thrombasthenia), pregnancy complications, endocrine disorders (Hyper/Hypothyroidism; Hyperprolactinemia; Adrenal Insufficiency; PCOS), anatomic abnormalities (Submucosal Myoma; Polyp; Tumor; Congenital Anomalies), trauma, retained foreign body, chronic illnesses (leukemia; liver dysfunction renal failure: HPO axis dysfunction is suggested as cause), cervical dysplasia, drugs and herbal supplements (Valproate, Carbamazepine; Ginkgo, ginger, garlic).[29]

The evaluation of an adolescent patient presenting with AUB includes: obtaining history regarding age of menarche, frequency of menses, duration and pattern of menses, presence or absence and timing of dysmenorrhea, presence of brown bleeding and clots during menses, and frequency of changing pads/tampons. Presence of clots and changing pads/tampons more than every 2 hours predicts blood loss of more than 80 ml.[30] Laboratory tests that should be considered include: CBC, PT/PTT, Fibrinogen, vWF Ag, Ristocetin cofactor activity, Factor VIII Activity, Specific Platelet Function Assay, and B-HCG.

Management of AUB needs to include the following goals: achieve hemodynamic stability, correct anemia, resume regular cycles, prevent recurrence, prevent long term consequences of anovulation. The approach to achieving hemodynamic stability may include: progesterone-Micronized progesterone[31,32] and antifibrinolytic therapy such as tranexamic acid. Micronized progesterone as opposed to synthetic progesterone has several benefits: it does not lower HDL and it does not interfere with glucose metabolism. The regimen for mild AUB includes: Micronized progesterone 200 mg po qhs for

[29] Cordier W, Steenkamp V. Herbal Remedies affecting coagulation: A review. *Pharm Biol.* 2012;50(4):443-452.

[30] Warner PE, Critchley HOD, Lumsden MA, Campbell-Brown M, Douglas A, Murray G. Menorrhagia I: Measured blood loss, clinical features, and outcome in women with heavy periods: A survey with follow-up data. *Am J Obstet Gynecol*. 2004;190:1216-1223.

[31] Malik S, Krishnaprasad K. Natural Micronized Progesterone Sustained Release (SR) and Luteal Phase: Role Defined!! *J Clin Diagn Res*. 2016;10(2):QE01-QE04.

[32] Emans SJ, Laufer MR, eds. *Pediatric and Adolescent Gynecology.* 6th ed. Philadelphia, PA: Lippincott Williams & Williams; 2012.

10-14 days. Patient may benefit from cycling for 4-6 months. The regimen for moderate to severe AUB includes: 1-Using a higher dose of micronized progesterone (200-400) especially in the setting of a patient who is overweight or; 2-Using a loading dose of micronized progesterone followed by a taper of this one: 200 mg qid for 4 days, 200 mg tid for 3 days, 200 mg bid for 2-14 days.

The chart of a patient experiencing AUB may demonstrate the following bleeding patterns:1-A pattern that is not Crescendo-Decrescendo or Decrescendo and that tends to be the same day to day; 2-Presence of brown bleeding; 3-Bleeding that is not associated with menses. Ovulatory and Follicular dysfunction may precede luteal dysfunction which in turn causes abnormal bleeding patterns.

In conclusion, charting of the menstrual cycle serves as a vital sign which may signal pathologic conditions, guides laboratory and ultrasonographic evaluation, and can be used in tracking progress after starting treatment. This article describes the use of the charting of the menstrual cycle as a tool when evaluating conditions in adolescent patients, such as PCOS and AUB. The approach presented is one that aims to find the underlying pathophysiologic process and treat this one with the goal of restoring normality to the menstrual cycle pattern.

Gender Dysphoria in Children

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ABSTRACT: Gender dysphoria (GD) of childhood describes a psychological condition in which children experience a marked incongruence between their experienced gender and the gender associated with their biological sex. When this occurs in the pre-pubertal child, GD resolves in the vast majority of patients by late adolescence. Currently there is a vigorous, albeit suppressed, debate among physicians, therapists, and academics regarding what is fast becoming the new treatment standard for GD in children. This new paradigm is rooted in the assumption that GD is innate, and involves pubertal suppression with gonadotropin releasing hormone (GnRH) agonists followed by the use of cross-sex hormones—a combination that results in the sterility of minors. A review of the current literature suggests that this protocol is founded upon an unscientific gender ideology, lacks an evidence base, and violates the long-standing ethical principle of "First do no harm."

Gender Dysphoria in Children: This Debate Concerns More than Science

Gender is a term that refers to the psychological and cultural characteristics associated with biological sex.[1]

It is a psychological concept and sociological term, not a biological one. Gender identity refers to an individual's awareness of being male or female and is sometimes referred to as an individual's "experienced gender." Gender dysphoria (GD) in children describes a psychological condition in which they experience marked incongruence between their experienced gender and the gender associated with their biological sex. They often express the belief that they are the opposite sex.[2] The prevalence rates of GD among children has been estimated to be less than 1%.[3] Sex differences in rate of referrals to specialty clinics vary by age. In pre-pubertal children, the ratio of boys to girls ranges from 2:1 to 4.5:1. In adolescents, the sex ratio is close to parity; in adults, the ratio of males to females range from 1:1 to 6.1:1.[2]

The debate over how to treat children with GD is primarily an ethical dispute; one that concerns physician worldview as much as science. Medicine does not occur in a moral vacuum; every therapeutic action or inaction is the result of a moral judgment of

some kind that arises from the physician's philosophical worldview. Medicine also does not occur in a political vacuum and being on the wrong side of sexual politics can have severe consequences for individuals who hold the politically incorrect view.

As an example, Dr. Kenneth Zucker, long acknowledged as a foremost authority on gender identity issues in children, has also been a lifelong advocate for gay and transgender rights. However, much to the consternation of adult transgender activists, Zucker believes that gender-dysphoric pre-pubertal children are best served by helping them align their gender identity with their anatomic sex. This view ultimately cost him his 30-year directorship of the Child Youth and Family Gender Identity Clinic (GIC) at the Center for Addiction and Mental Health in Toronto.[4,5]

Many critics of pubertal suppression hold a modernist teleological worldview. They find it self-evident that there is a purposeful design to human nature, and that cooperation with this design leads to human flourishing. Others, however, identify as post-modernists who reject teleology. What unites the two groups is a traditional interpretation of "First do no harm." For example, there is a growing online community of gay-affirming physicians, mental health professionals, and academics with a webpage entitled "First, do no harm: youth trans critical professionals." They write:

> We are concerned about the current trend to quickly diagnose and affirm young people as transgender, often setting them down a path toward medical transition…. We feel that unnecessary surgeries and/or hormonal treatments which have not been proven safe in the long-term represent significant risks for young people. Policies that encourage—either directly or indirectly—such medical treatment for young people who may not be able to evaluate the risks and benefits are highly suspect, in our opinion.[6]

Advocates of the medical interventionist paradigm, in contrast, are also post-modernists but hold a subjective view of "First do no harm." Dr. Johanna Olson-Kennedy, an adolescent medicine specialist at Children's Hospital Los Angeles, and leader in pediatric gender transitioning, has stated that "[First do no harm] is really subjective. [H]istorically we come from a very paternalistic perspective… [in which] doctors are really given the purview of deciding what is going to be harmful and what isn't. And that, in the world of gender, is really problematic."[7] Not only does she claim that "First do no harm" is subjective, but she later also states that it should be left to the child to decide what constitutes harm based upon their own subjective thoughts and feelings.[7] Given the cognitive and experiential immaturity of the child and adolescent, the American College of Pediatricians (the College) finds this highly problematic and unethical.

Gender Dysphoria as the Result of an Innate Internal Sexed Identity

Professor of social work, Dr. William Brennan, has written that "[t]he power of language to color one's view of reality is profound."[8] It is for this reason that linguistic engineering always precedes social engineering — even in medicine. Many hold the mistaken belief that gender once meant biological sex. Though the terms are often used interchangeably they were never truly synonymous.[9,10] Feminists of the late 1960's and

1970's used gender to refer to a "social sex" that could differ from one's "biological sex" in order to overcome unjust discrimination against women rooted in sex stereotypes. These feminists are largely responsible for mainstreaming the use of the word gender in place of sex. More recently, in an attempt to eliminate heteronormativity, queer theorists have expanded gender into an excess of 50 categories by merging the concept of a social sex with sexual attractions.[9] However, neither usage reflects the original meaning of the term.

Prior to the 1950s, gender applied only to grammar not to persons.[9,10] Latin based languages categorize nouns and their modifiers as masculine or feminine and for this reason are still referred to as having a gender. This changed during the 1950s and 1960s as sexologists realized that their sex reassignment agenda could not be sufficiently defended using the words sex and transsexual. From a purely scientific standpoint, human beings possess a biologically determined sex and innate sex differences. No sexologist could actually change a person's genes through hormones and surgery. Sex change is objectively impossible. Their solution was to hijack the word gender and infuse it with a new meaning that applied to persons. John Money, PhD was among the most prominent of these sexologists who redefined gender to mean 'the social performance indicative of an internal sexed identity.'[10] In essence, these sexologists invented the ideological foundation necessary to justify their treatment of transsexualism with sex reassignment surgery and called it gender. It is this man-made ideology of an 'internal sexed identity' that now dominates mainstream medicine, psychiatry and academia. This linguistic history makes it clear that gender is not and never has been a biological or scientific entity. Rather, gender is a socially and politically constructed concept.

In their "Overview of Gender Development and Gender Nonconformity in Children and Adolescents," Forcier and Olson-Kennedy dismiss the binary model of human sexuality as "ideology" and present an "alternate perspective" of "innate gender identity" that presents along a "gender continuum." They recommend that pediatricians tell parents that a child's "real gender" is what he or she feels it to be because "a child's brain and body may not be on the same page."[11]

Forcier and Olson-Kennedy's claim of an innate discordance between a child's brain and body derives from diffusion-weighted MRI scans that demonstrate the pubertal testosterone surge in boys increases white matter volume, as well as from brain studies of adults who identify as transgender. A study by Rametti and colleagues found that the white matter microstructure of the brains of female-to-male (FtM) transsexual adults, who had not begun testosterone treatment, more closely resembled that of men than that of women.[12] Other diffusion-weighted MRI studies have concluded that the white matter microstructure in both FtM and male-to-female (MtF) transsexuals falls halfway between that of genetic females and males.[13] These studies, however, are of questionable clinical significance due to the small number of subjects and the existence of neuroplasticity. Neuroplasticity is the well-established phenomenon in which long-term behavior alters brain microstructure. There is no evidence that people are born with brain microstructures that are forever unalterable, but there is significant evidence that experience changes brain microstructure.[14] Therefore, if and when valid transgender

brain differences are identified, these will likely be the result of transgender behavior rather than its cause. More importantly, however, is the fact that the brains of all male infants are masculinized prenatally by their own endogenous testosterone, which is secreted from their testes beginning at approximately eight weeks' gestation. Female infants, of course, lack testes, and therefore, do not have their brains masculinized by endogenous testosterone.[15,16,17] For this reason, barring one of the rare disorders of sex development (DSD), boys are not born with feminized brains, and girls are not born with masculinized brains.

Behavior geneticists have known for decades that while genes and hormones *influence* behavior, they do not hard-wire a person to think, feel, or behave in a particular way. The science of epigenetics has established that genes are not analogous to rigid "blueprints" for behavior. Rather, humans "develop traits through the dynamic process of gene-environment interaction… [genes alone] don't determine who we are."[18] Regarding the etiology of transgenderism, twin studies of adult transsexuals prove definitively that prenatal genetic and hormone influence is minimal.

Twin studies are instrumental in elucidating the degree to which a trait is biologically determined before birth. Since monozygotic twins are conceived with exactly the same DNA and are exposed to the same prenatal environment, traits that are solely determined by genes and/or by the prenatal environment, will manifest in both identical twins 100% of the time. Race is an example of a trait that identical twins share 100 percent of the time because it is solely determined by genes.

The largest transsexual twin study to date examines 110 twin pairs and was published by Dr. Milton Diamond in the May 2013 issue of the *International Journal of Transgenderism*.[19] Table 5 documents that the number of monozygotic twin pairs concordant for transsexualism is greater than that of dizygotic twin pairs. This suggests a possible biological predisposition for gender dysphoria. The most significant data entry, however, is the low number of concordant monozygotic twin pairs. Only 21 monozygotic twin pairs out of a total of 74 monozygotic pairs, or 28 percent, were concordant for transsexualism; the remaining 72 percent of identical twins were discordant for transsexualism. This means that at least 72 percent of what accounts for transsexualism in one twin and not in the other occurs *after* birth and is *not* biological. Such a high discordance rate among identical twins proves that no one is born pre-determined to have gender dysphoria let alone pre-determined to identify as transgender or transsexual. This is consistent with the dramatic rates of resolution of gender dysphoria documented among children when they are not encouraged to impersonate the opposite sex. The low concordance rate also supports the theory that persistent GD is due predominately to the impact of non-shared environmental influences upon certain biologically vulnerable children. To be clear, twin studies alone establish that the "alternate perspective" of an "innate gender identity" arising from prenatally "feminized" or "masculinized" brains trapped in the wrong body is in fact an ideological belief that has no basis in rigorous science.

A teleological binary view of human sexuality, in contrast, is compatible with biological reality. The norm for human design is to be conceived either male or female.

Sex chromosome pairs "XY" and "XX" are genetic determinants of sex, male and female, respectively. They are not genetic markers of a disordered body or birth defect. Human sexuality is binary by design with the purpose being the reproduction of our species. This principle is self-evident. *Barring one of the rare disorders of sex development (DSD), no infant is "assigned" a sex or a gender at birth; rather birth sex declares itself anatomically in utero and is clearly evident and acknowledged at birth.*

The exceedingly rare DSDs, including but not limited to androgen insensitivity syndrome and congenital adrenal hyperplasia, are all medically identifiable deviations from the human binary sexual norm. Unlike individuals with a normal genotype and hormonal axis who identify as "transgender," those with DSD have an innate biological condition. Sex assignment in individuals with DSDs is complex and dependent on a variety of genetic, hormonal, and physical factors. Nevertheless, the 2006 consensus statement of the Intersex Society of North America did not endorse DSD as a third sex.[20]

Post-natal Factors Predominate in the Development and Persistence of GD

Since identical twins also usually grow up under the same family conditions, twin studies, including Dr. Diamond's, demonstrate that it is non-shared post-natal events (non-shared environmental factors) that predominate in the development and persistence of gender dysphoria in one twin versus the other. This is not surprising since it is well accepted that a child's emotional and psychological development is impacted by positive and negative experiences from infancy forward. Family and peer relationships, one's school and neighborhood, the experience of any form of abuse, media exposure, chronic illness, war, and natural disasters are all examples of environmental factors that impact an individual's emotional, social, and psychological development. *There is no single-family dynamic, social situation, adverse event, or combination thereof that has been found to destine any child to develop GD.* This fact, together with twin studies, suggests that there are many paths that may lead to GD in certain biologically vulnerable children. The literature regarding the etiology and psychotherapeutic treatment of childhood GD is heavily based upon clinical case studies. These studies suggest that social reinforcement, parental psychopathology, family dynamics, and social contagion facilitated by mainstream and social media, all contribute to the development and/or persistence of GD in some vulnerable children. There may be other as yet unrecognized contributing factors as well.

Most parents of children with GD recall their initial reactions to their child's cross-sex dressing and other cross-sex behaviors to have been tolerance and/or encouragement. Sometimes parental psychopathology is at the root of the social reinforcement. For example, among mothers of boys with GD who had desired daughters, a small subgroup experienced what has been termed "pathologic gender mourning." Within this subgroup the mother's desire for a daughter was acted out by the mother actively cross-dressing her son as a girl. These mothers typically suffered from severe depression that was relieved when their sons dressed and acted in a feminine manner.[21]

A large body of clinical literature documents that fathers of feminine boys report spending less time with their sons between the ages of two and five as compared with fathers of control boys. This is consistent with data that shows feminine boys feel closer to their mothers than to their fathers. In his clinical studies of boys with GD, Stoller observed that most had an overly close relationship with their mother and a distant, peripheral relationship with their father. He postulated that GD in boys was a "developmental arrest … in which an excessively close and gratifying mother-infant symbiosis, undisturbed by father's presence, prevents a boy from adequately separating himself from his mother's female body and feminine behavior."[21]

It has also been found that among children with GD, the rate of maternal psychopathology, particularly depression and bipolar disorder is "high by any standard." Additionally, a majority of the fathers of GD boys are easily threatened, exhibit difficulty with affect regulation, and possess an inner sense of inadequacy. These fathers typically deal with their conflicts by overwork or otherwise distance themselves from their families. Most often, the parents fail to support one another, and have difficulty resolving marital conflicts. This produces an intensified air of conflict and hostility. In this situation, the boy becomes increasingly unsure about his own self-value because of the mother's withdrawal or anger and the father's failure to intercede. The boy's anxiety and insecurity intensify, as does his anger, which may all result in his inability to identify with his biological sex.[22]

Systematic studies regarding girls with GD and the parent-child relationship have not been conducted. However, clinical observations suggest that the relationship between mother and daughter is most often distant and marked by conflict, which may lead the daughter to disidentify from the mother. In other cases, masculinity is praised while femininity is devalued by the parents. Furthermore, there have been cases in which girls are afraid of their fathers who may exhibit volatile anger up to and including abuse toward the mother. A girl may perceive being female as unsafe, and psychologically defend against this by feeling that she is really a boy; subconsciously believing that if she were a boy she would be safe from and loved by her father.[21]

There is evidence that psychopathology and/or developmental diversity may precipitate GD in adolescents, particularly among young women. Recent research has documented increasing numbers of adolescents who present to adolescent gender identity clinics and request sex reassignment (SR). Kaltiala-Heino and colleagues sought to describe the adolescent applicants for legal and medical sex reassignment during the first two years of an adolescent gender identity clinic in Finland, in terms of sociodemographic, psychiatric, and gender identity related factors and adolescent development. They conducted a structured quantitative retrospective chart review and qualitative analysis of case files of all adolescent SR applicants who entered the assessment by the end of 2013. They found that the number of referrals exceeded expectations in light of epidemiological knowledge. Natal girls were markedly overrepresented among applicants. Severe psychopathology preceding the onset of GD was common. Many youth

were on the autism spectrum. These findings do not fit the commonly accepted image of a gender dysphoric child. The researchers conclude that treatment guidelines need to consider GD in minors in the context of severe psychopathology and developmental difficulties.[23]

Anecdotally, there is also an increasing trend among adolescents to self-diagnose as transgender after binges on social media sites such as Tumblr, Reddit, and YouTube. This suggests that social contagion may be at play. In many schools and communities, there are entire peer groups "coming out" as trans at the same time.[6] Finally, strong consideration should be given to investigating a causal association between adverse childhood events, including sexual abuse, and transgenderism. The overlap between childhood gender discordance and an adult homosexual orientation has long been acknowledged.[24] There is also a large body of literature documenting a significantly greater prevalence of childhood adverse events and sexual abuse among homosexual adults as compared to heterosexual adults. Andrea Roberts and colleagues published a study in 2013 that found "half to all of the elevated risk of childhood abuse among persons with same-sex sexuality compared to heterosexuals was due to the effects of abuse on sexuality."[25] It is therefore possible that some individuals develop GD and later claim a transgender identity as a result of childhood maltreatment and/or sexual abuse. This is an area in need of research.

GD as an Objective Mental Disorder

Psychology has increasingly rejected the concept of norms for mental health, focusing instead on emotional distress. The American Psychiatric Association (APA), for example, explains in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) that GD is listed therein not due to the discrepancy between the individual's thoughts and physical reality, but due to the presence of emotional distress that hampers social functioning. The DSM-V also notes that a diagnosis is required for insurance companies to pay for cross-sex hormones and sex reassignment surgery (SRS) to alleviate the emotional distress of GD. Once the distress is relieved, GD is no longer considered a disorder.[2]

There are problems with this reasoning. Consider the following examples: a girl with anorexia nervosa has the persistent mistaken belief that she is obese; a person with body dysmorphic disorder (BDD) harbors the erroneous conviction that she is ugly; a person with body integrity identity disorder (BIID) identifies as a disabled person and feels trapped in a fully functional body. Individuals with BIID are often so distressed by their fully capable bodies that they seek surgical amputation of healthy limbs or the surgical severing of their spinal cord.[26] Dr. Anne Lawrence, who is transgender, has argued that BIID has many parallels with GD.[27] The aforementioned false beliefs, like GD, are not merely emotionally distressing for the individuals but also life-threatening. In each case, surgery to "affirm" the false assumption (liposuction for anorexia, cosmetic surgery for BDD, amputation or surgically induced paraplegia for BIID, sex reassignment surgery for GD) may very well alleviate the patient's emotional distress, but will do nothing to

address the underlying psychological problem, and may result in the patient's death. Completely removed from physical reality, the art of psychotherapy will diminish as the field of psychology increasingly devolves into a medical interventionist specialty, with devastating results for patients.

Alternatively, a minimal standard could be sought. Normality has been defined as "that which functions according to its design."[28] One of the chief functions of the brain is to perceive physical reality. Thoughts that are in accordance with physical reality are normal. Thoughts that deviate from physical reality are abnormal—as well as potentially harmful to the individual or to others. This is true whether or not the individual who possesses the abnormal thoughts feels distress. A person's belief that he is something or someone he is not is, at best, a sign of confused thinking; at worst, it is a delusion. Just because a person thinks or feels something does not make it so. This would be true even if abnormal thoughts were biologically "hardwired."

The norm for human development is for an individual's thoughts to align with physical reality; for an individual's gender identity to align with biologic sex. People who identify as "feeling like the opposite sex" or "somewhere in between" or some other category do not comprise a third sex. They remain biological men or biological women. GD is a problem that resides in the mind not in the body. Children with GD do not have a disordered body—even though they feel as if they do. Similarly, a child's distress over developing secondary sex characteristics does not mean that puberty should be treated as a disease to be halted, because puberty is not, in fact, a disease. Likewise, although many men with GD express the belief that they are a "feminine essence" trapped in a male body, this belief has no scientific basis.

Until recently, the prevailing worldview with respect to childhood GD was that it reflected abnormal thinking or confusion on the part of the child that may or may not be transient. Consequently, the standard approach was either watchful waiting or pursuit of family and individual psychotherapy.[1,2] The goals of therapy were to address familial pathology if it was present, treat any psychosocial morbidities in the child, and aid the child in aligning gender identity with biological sex.[21,22] Experts on both sides of the pubertal suppression debate agree that within this context, 80 percent to 95 percent of children with GD accepted their biological sex by late adolescence.[29] This worldview began to shift, however, as adult transgender activists increasingly promoted the "feminine essence" narrative to secure social acceptance.[10] In 2007, the same year that Boston Children's Hospital opened the nation's first pediatric gender clinic, Dr. J. Michael Bailey wrote:

> Currently the predominant cultural understanding of male-to-female transsexualism is that all male-to- female (MtF) transsexuals are, essentially, women trapped in men's bodies. This understanding has little scientific basis, however, and is inconsistent with clinical observations. Ray Blanchard has shown that there are two distinct subtypes of MtF transsexuals. Members of one subtype, homosexual transsexuals, are best understood as a type of homosexual male. The other subtype, autogynephilic transsexuals, are (sic) motivated by the erotic desire to become women. The persistence

> of the predominant cultural understanding, while explicable, is damaging to science and to many transsexuals.[30]

As the "feminine essence" view persisted, the suffering of transgender adults was invoked to argue for the urgent rescue of children from the same fate by early identification, affirmation, and pubertal suppression. It is now alleged that discrimination, violence, psychopathology, and suicide are the direct and inevitable consequences of withholding social affirmation and puberty blockers or cross-sex hormones from a gender dysphoric child.[31] Yet, the fact that 80 percent to 95 percent of gender-dysphoric youth emerge physically and psychologically intact after passing through puberty without social affirmation refutes this claim.[29] Furthermore, over 90 percent of people who die of suicide have a diagnosed mental disorder.[32] There is no evidence that gender-dysphoric children who commit suicide are any different. Therefore, the cornerstone for suicide prevention should be the same for them as for all children: early identification and treatment of psychological co-morbidities.

Nevertheless, there are now 40 gender clinics across the United States that promote the use of pubertal suppression and cross-sex hormones in children. The rationale for suppression is to allow the gender- dysphoric child time to explore gender identity free from the emotional distress triggered by the onset of secondary sex characteristics. The standards followed in these clinics are based on "expert opinion." There is not a single large, randomized, controlled study that documents the alleged benefits and potential harms to gender-dysphoric children from pubertal suppression and decades of cross-sex hormone use. Nor is there a single long-term, large, randomized, controlled study that compares the outcomes of various psychotherapeutic interventions for childhood GD with those of pubertal suppression followed by decades of toxic synthetic steroids. In today's age of "evidence-based medicine," this should give everyone pause. Of greater concern is that pubertal suppression at Tanner Stage 2 (usually 11 years of age) followed by the use of cross-sex hormones will leave these children sterile and without gonadal tissue or gametes available for cryo-preservation.[33,34,35]

Neuroscience clearly documents that the adolescent brain is cognitively immature and lacks the adult capacity needed for risk assessment prior to the early to mid-twenties.[36] There is a serious ethical problem with allowing irreversible, life-changing procedures to be performed on minors who are too young to give valid consent themselves. This ethical requirement of informed consent is fundamental to the practice of medicine, as emphasized by the U.S. Department of Health & Human Services website: "The voluntary consent of the human subject is absolutely essential."[37] Moreover, when an individual is sterilized, even as a secondary outcome of therapy, lacking full, free, and informed consent, it is a violation of international law.[38]

Transgender-Affirming Protocol: What Is the Evidence Base?

Over the past two decades, Hayes, Inc. has grown to become an internationally recognized research and consulting firm that evaluates a wide range of medical technologies to determine the impact on patient safety, health outcomes, and resource utilization.

This corporation conducted a comprehensive review and evaluation of the scientific literature regarding the treatment of GD in adults and children in 2014. It concluded that although "evidence suggests positive benefits" to the practice of using sex reassignment surgery in gender dysphoric adults, "serious limitations [inherent to the research] permit only weak conclusions."[39] Similarly, Hayes, Inc. found the practice of using cross-sex hormones for gender dysphoric adults to be based on "very low" quality of evidence:

> Statistically significant improvements have not been consistently demonstrated by multiple studies for most outcomes. Evidence regarding quality of life and function in male-to-female (MtF) adults was very sparse. Evidence for less comprehensive measures of well-being in adult recipients of cross-sex hormone therapy was directly applicable to GD patients but was sparse and/or conflicting. The study designs do not permit conclusions of causality and studies generally had weaknesses associated with study execution as well. There are potentially long-term safety risks associated with hormone therapy but none have been proven or conclusively ruled out.[40]

Regarding treatment of children with GD using gonadotropin releasing hormone (GnRH) agonists and cross-sex hormones, Hayes, Inc. awarded its lowest rating indicating that the literature is "too sparse and the studies [that exist are] too limited to suggest conclusions."[40]

Gender Clinics Proliferate Across United States Despite Lack of Medical Evidence

In 2007 Dr. Norman Spack, a pediatric endocrinologist and founder of the nation's first gender clinic at Boston Children's Hospital, launched the pubertal suppression paradigm in the United States.[41] It consists of first affirming the child's false self-concept by instituting name and pronoun changes, and facilitating the impersonation of the opposite sex within and outside of the home. Next, puberty is suppressed via GnRH agonists as early as age 11 years, and then finally, patients may graduate to cross-sex hormones at age 16 in preparation for sex-reassignment surgery as an older adolescent or adult.[42] Endocrine Society guidelines currently prohibit the use of cross-sex hormones before age 16 but this prohibition is being reconsidered.[43] Some gender specialists are already bypassing pubertal suppression and instead putting children as young as 11 years old directly onto cross-sex hormones.[44] The rationale is that the child will experience the pubertal development of the desired sex and thereby avoid the iatrogenic emotional distress from maintaining a pre-pubertal appearance as peers progress along their natural pubertal trajectory.

In 2014 there were 24 gender clinics clustered chiefly along the East Coast and in California; one year later there were 40 across the nation. Dr. Ximena Lopez, a pediatric endocrinologist at Children's Medical Center Dallas, and a member of that program's GENder Education and Care, Interdisciplinary Support program (Genecis) stated, "[Use of this protocol is] growing really fast. And the main reason is [that] parents are demanding it and bringing patients to the door of pediatric endocrinologists because

they know this is available."[45] Notice, the *main* reason for the protocol's increased use is parent demand; not evidence-based medicine.

Risks of GnRH Agonists

The GnRH agonists used for pubertal suppression in gender dysphoric children include two that are approved for the treatment of precocious puberty: leuprolide by intramuscular injection with monthly or once every three month dosing formulations, and histrelin, a subcutaneous implant with yearly dosing.[34] In addition to preventing the development of secondary sex characteristics, GnRH agonists arrest bone growth, decrease bone accretion, prevent the sex-steroid dependent organization and maturation of the adolescent brain, and inhibit fertility by preventing the development of gonadal tissue and mature gametes for the duration of treatment. If the child discontinues the GnRH agonists, puberty will ensue.[34,42] Consequently, the Endocrine Society maintains that GnRH agonists, as well as living socially as the opposite sex, are fully reversible interventions that carry no risk of permanent harm to children.[42] However, social learning theory, neuroscience, and the single long-term follow-up study of adolescents who have received pubertal suppression described below challenge this claim.

In a follow-up study of their first 70 pre-pubertal candidates to receive puberty suppression, de Vries and colleagues documented that all subjects eventually embraced a transgender identity and requested cross-sex hormones.[46] This is cause for concern. Normally, 80 percent to 95 percent of pre-pubertal youth with GD do not persist in their GD. To have 100 percent of pre-pubertal children choose cross-sex hormones suggests that the protocol itself inevitably leads the individual to identify as transgender. There is an obvious self-fulfilling nature to encouraging a young child with GD to socially impersonate the opposite sex and then institute pubertal suppression. Given the well-established phenomenon of neuroplasticity, the repeated behavior of impersonating the opposite sex will alter the structure and function of the child's brain in some way—potentially in a way that will make identity alignment with the child's biologic sex less likely. This, together with the suppression of puberty that prevents further endogenous masculinization or feminization of the brain, causes the child to remain either a gender non-conforming pre-pubertal boy disguised as a pre- pubertal girl, or the reverse. Since their peers develop normally into young men or young women, these children are left psychosocially isolated. They will be less able to identify as being the biological male or female they actually are. A protocol of impersonation and pubertal suppression that sets into motion a single inevitable outcome (transgender identification) that requires lifelong use of toxic synthetic hormones, resulting in infertility, is neither fully reversible nor harmless.

GnRH Agonists, Cross-sex Hormones, and Infertility

Since GnRH agonists prevent the maturation of gonadal tissue and gametes in both sexes, youth who graduate from pubertal suppression at Tanner Stage 2 to cross-sex hormones will be rendered infertile without any possibility of having genetic offspring

in the future because they will lack gonadal tissue and gametes for cryo-preservation. The same outcome will occur if pre-pubertal children are placed directly upon cross-sex hormones. Older adolescents who declined pubertal suppression are advised to consider cryo-preservation of gametes prior to beginning cross-sex hormones. This will allow them to conceive genetic offspring in the future via artificial reproductive technology. While there are documented cases of transgendered adults who stopped their cross-sex hormones in order to allow their bodies to produce gametes, conceive, and have a child, there is no absolute guarantee that this is a viable option in the long term. Moreover, transgendered individuals who undergo sex reassignment surgery and have their reproductive organs removed are rendered permanently infertile.[34,35,36]

Additional Health Risks Associated with Cross-sex Hormones

Potential risks from cross-sex hormones to children with GD are based on the adult literature. Recall that regarding the adult literature, the Hayes report states: "There are potentially long-term safety risks associated with hormone therapy but none have been proven or conclusively ruled out."[40] For example, most experts agree that there is an increased risk of coronary artery disease among MtF adults when placed on oral ethinyl estradiol; therefore, alternative estrogen formulations are recommended. However, there is one study of MtF adults using alternative preparations that found a similar increased risk. Therefore, this risk is neither established nor ruled out.[47,48,49] Children who transition will require these hormones for a significantly greater length of time than their adult counterparts. Consequently, they may be more likely to experience physiologically theoretical though rarely observed morbidities in adults. With these caveats, it is most accurate to say that oral estrogen administration to boys *may* place them at risk for experiencing: thrombosis/thromboembolism; cardiovascular disease; weight gain; hypertrigyceridemia; elevated blood pressure; decreased glucose tolerance; gallbladder disease; prolactinoma; and breast cancer.[47,48,49] Similarly, girls who receive testosterone *may* experience an elevated risk for: low HDL and elevated triglycerides; increased homocysteine levels; hepatotoxicity; polycythemia; increased risk of sleep apnea; insulin resistance; and unknown effects on breast, endometrial and ovarian tissues.[47,48,49] In addition, girls may legally obtain a mastectomy as early as 16 years of age after receiving testosterone therapy for at least one year; this surgery carries its own set of irreversible risks.[34]

The Post-Pubertal Adolescent with GD

As previously noted, 80 percent to 95 percent of pre-pubertal children with GD will experience resolution by late adolescence if not exposed to social affirmation and medical intervention. This means that 5 percent to 20 percent will persist in their GD as young adults. Currently, there is no medical or psychological test to determine which children will persist in their GD as young adults. Pre-pubertal children with GD who persist in their GD beyond puberty are more likely to also persist into adulthood. The Endocrine Society and others, including Dr. Zucker, therefore regard it reasonable to

affirm children who persist in their GD beyond puberty, as well as those who present after puberty, and to proceed with cross-sex hormones at age 16 years.[42]

The College disagrees for the following reasons. First, not all adolescents with GD inevitably go on to trans-identification, but cross-sex hormones inevitably result in irreversible changes for all patients. Second, the young adolescent is simply not sufficiently mature to make significant medical decisions. The adolescent brain does not achieve the capacity for full risk assessment until the early to mid-twenties. There is a significant ethical problem with allowing minors to receive life-altering medical interventions including cross-sex hormones and, in the case of natal girls, bilateral mastectomy, when they are incapable of providing informed consent for themselves. As stated earlier, the College is also concerned about an increasing trend among adolescents to self-diagnose as transgender after binges on social media sites. While many of these adolescents will seek out a therapist after self-identifying, many states have been forced by non-scientific political pressure to ban so-called "conversion therapy." These bans prevent therapists from exploring not only a young person's sexual attractions and identity, but also his or her gender identity. Therapists are not allowed to ask why an adolescent believes he or she is transgender; may not explore underlying mental health issues; cannot consider the symbolic nature of the gender dysphoria; and may not look at possible confounding issues such as social media use or social contagion.[6]

Impact of Sex Reassignment in Adults as It Relates to Risk in Children

Surveys suggest that transgender adults express a sense of "relief" and "satisfaction" following the use of hormones and sex reassignment surgery (SRS). However, SRS does not result in a level of health equivalent to that of the general population. [50]

For example, a 2001 study of 392 male-to-female and 123 female-to-male transgender persons found that 62 percent of the male-to-female (MtF) and 55 percent of the female-to-male (FtM) transgender persons were depressed. Nearly one third (32 percent) of each population had attempted suicide.[51] Similarly, in 2009, Kuhn and colleagues found considerably lower general health and general life satisfaction among 52 MtF and 3 FtM transsexuals fifteen years after SRS when compared with controls.[52] Finally, a thirty-year follow-up study of post-operative transgender patients from Sweden found that *the rate of suicide among post-operative transgender adults was nearly twenty times greater than that of the general population. To be clear, this does not prove that sex reassignment causes an increased risk of suicide or other psychological morbidities. Rather, it indicates that sex reassignment alone does not provide the individual with a level of mental health on par with the general population. The authors summarized their findings as follows:* "Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behavior, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, though alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group."[50]

It is noteworthy that these mental health disparities are observed in one of the most lesbian, gay, bisexual and transgender (LGBT) affirming nations of the world. It suggests that these health differences are not due primarily to social prejudice, but rather due to the adult transgender condition or lifestyle. This is also consistent with an American study published in the *Journal of LGBT Health* in 2008 that found discrimination did not account for the mental health discrepancies between LGBT-identified individuals and the heterosexual population.[53]

Absent hormonal and surgical intervention, only 5-20 percent of pre-pubertal children with GD will face a transgender adulthood which seems to predispose them to certain morbidities and an increased risk of early death. In contrast, the single study of pre-pubertal children with GD who received pubertal suppression makes clear that 100 percent of these children will face a transgender adulthood. Therefore, the current transgender affirming interventions at pediatric gender clinics will statistically yield this outcome for the remaining 80 to 95 percent of pre-pubertal children with GD who otherwise would have identified with their biological sex by adulthood.

Recommendations for Research

Identical twin studies establish that post-natal environmental factors exert a significant influence over the development of GD and transgenderism. Data also reflects a greater than 80% resolution rate among pre-pubertal children with GD. Consequently, identification of the various environmental factors and pathways that trigger GD in biologically vulnerable children should be one focus of research. Particular attention should be given to the impact of childhood adverse events and social contagion. Another area of much needed research is within psychotherapy. Large long term longitudinal studies in which children with GD and their families are randomized to treatment with various therapeutic modalities and assessed across multiple measures of physical and social emotional health are desperately needed and should have been launched long ago. In addition, long term follow-up studies that assess objective measures of physical and mental health of post-surgical transsexual adults must include a matched control group consisting of transgender individuals who do not undergo SRS. This is the only way to test the hypothesis that SRS itself may cause more harm to individuals than they otherwise would experience with psychotherapy alone.

Conclusion

Gender dysphoria (GD) in children is a term used to describe a psychological condition in which a child experiences marked incongruence between his or her experienced gender and the gender associated with the child's biological sex. Twin studies demonstrate that GD is not an innate trait. Moreover, barring pre-pubertal affirmation and hormone intervention for GD, 80 percent to 95 percent of children with GD will accept the reality of their biological sex by late adolescence.

The treatment of GD in childhood with hormones effectively amounts to mass experimentation on, and sterilization of, youth who are cognitively incapable of pro-

viding informed consent. There is a serious ethical problem with allowing irreversible, life-changing procedures to be performed on minors who are too young to give valid consent themselves; adolescents cannot understand the magnitude of such decisions.

Ethics alone demands an end to the use of pubertal suppression with GnRH agonists, cross-sex hormones, and sex reassignment surgeries in children and adolescents. The College recommends an immediate cessation of these interventions, as well as an end to promoting gender ideology via school curricula and legislative policies. Healthcare, school curricula and legislation must remain anchored to physical reality. Scientific research should focus upon better understanding the psychological underpinnings of this disorder, optimal family and individual therapies, as well as delineating the differences among children who resolve with watchful waiting versus those who resolve with therapy and those who persist despite therapy.

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The American College of Pediatricians is a national medical association of licensed physicians and healthcare professionals who specialize in the care of infants, children, and adolescents. The mission of the College is to enable all children to reach their optimal, physical and emotional health and well-being.

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How to Have a Pro-Life Private Practice

Bella Natural Woman's Care, Denver, Colorado
Dr. Leigh Bauer and Dede Chism, Founder and Nurse Practitioner

Tepeyac OB/GYN, Fairfax, VA and
Divine Mercy Care (Tepeyac's Fundraising Entity)
Dr. John Bruchalski and Will Waldron, Executive Director of Divine Mercy Care

Morning Star OB/GYN, Gilbert, AZ
Dr. Clint Leonard and Christine Accurso, Practice Administrator

We are starting a unique pro-life private practice movement at a time when private practices are out of vogue. Our hope is that we can become a resource for anyone exploring the rare but growing model of medical pro-life private practice. Whether or not you ever become part of this movement, we think it will interest you.

We are the leaders of three pro-life private practices, and we hope that, by studying our three case models from the angles of spirituality, medicine, and business, we can demonstrate how pro-life private practice can work. All three models are distinct, but share in common a pledge to Catholic ethics, broad community engagement, and a commitment to seeing both the poor and the insured in our offices.

Introduction

Dr. Bruchalski, Tepeyac OB/GYN

I am well aware that most young doctors today, coming out of their residencies, feel conflicted about the positives and negatives of various career options. It isn't as simple as just deciding to be a doctor or what specialty to practice. It is much more complex when you consider the options of private practice, practices linked to health networks like Privia, practices connected to hospitals, large multispecialty groups such as Kaiser Permanente, ER Hospitalist options, or research opportunities.

One major appeal of larger group options is that it often leaves the business administration to others so a provider can focus on medicine. Sometimes this means greater revenue and better opportunities for work/life balance. All these factors must be considered carefully when discerning the best fit for your future in medicine.

When OB/GYN is involved, things get even more complicated. If you are an OB/GYN, you have entered what may be the most controversial field of medicine in our

day. For those of us who hold pro-life views, it is more and more difficult to even get through school, let alone practice in a place where you and your partners are all practicing 100% in line with your personal viewpoints. Things have changed since I began in 1994 in ways that makes this harder and harder. But it is not impossible.

Personally, I felt that I could not compromise my faith under any circumstance. Many pro-life OB/GYNs feel differently about contraception and sterilization; about interventionist vs. restorative medical circumstances; about abortion in harder cases like fetal disability, fetal abnormality, rape, incest, and the mother's health. Once we draw our personal lines, we then must decide how much we can tolerate from working in practices with partners that don't share our views. For me and my partners, private practice became and remains the best solution. For many of us, spirituality was a large factor in this decision.

Leaving the field behind isn't an option; we all feel called into our vocation of medicine, and specifically OB/GYN, as the place we were using our talents that God gave us to serve others. Yet, we had all compromised our core spiritual principles in the past when working for others, and we were done with that. Each of us longed for something more. Tepeyac OB/GYN gives that "something more than medicine" – to our patients, but also to us as medical professionals. It allows us to add in spirituality and conscience to our approach. We serve the dignity of the human person while caring for patients in an atmosphere of integration and thoroughness. Whereas many doctors volunteer at free clinics or go on wonderful medical mission trips, *we feel called to integrate seeing "the least of these" as part of our everyday practice – folding them into our hours every day*. Thus Tepeyac has adopted a non-profit medical model sustained in part by our fundraising umbrella organization Divine Mercy Care.

But we mostly see insured and self-pay patients who really want excellent care. These might be Christian or Catholic women who like our faith-based approach; others just love our doctors and respect our excellence. We integrate body/mind/spirit medicine, listening and cooperating with the language of our bodies.

Tepeyac's philosophical approach was studied by Bella and Morning Star as they adapted the model to their own regions and needs. I am so pleased to see what they have become, and so pleased that we can share together how we make private practice work day in and day out.

Spiritual Standards and Considerations— The Call to OB/GYN Private Practice

Dr. Bauer, Bella Natural Woman's Care

I decided from a young age that I wanted to pursue medicine and carried this conviction and sense of mission with me through my youth. I grew more and more convinced of the need for good Catholic doctors as we navigated our own health care. Growing up, my mother wisely sought to have a pro-life doctor taking care of us, especially after my sister and I were continually faced with being told to start birth control

as teenagers (as so many young women are pressured to do). This demonstrated to me the importance of having a doctor that understood and accepted the Catholic approach to women's health. It also lit a spark in me to fight for a true understanding of women's dignity in health care.

It was at this point that we were fortunate enough to establish care with a faithful Catholic doctor who was very pro-life. She quickly became my mentor and the person I aspired to be like. Her inspirational influence was strengthened when she invited me to shadow her while she volunteered at a pro-life women's free clinic. I was touched by her humble service to women in need, and I began to feel strongly that this is where I was meant to be.

I can say that I have met my fair share of challenges along my journey. Residency, as many of you know, was four years of being challenged beyond my perceived limits. However, I was blessed to be in a program that was very supportive of my Catholic faith and ethical convictions. On the flip side of that, I was not challenged to stand up for those values. Instead, the biggest challenge came when I was first employed after residency as a hospital-employed OB/GYN at a secular hospital. I made it very clear from the start that I did not prescribe birth control or do tubal ligations. However, as time progressed in this practice, it became less clear to me *why* I did not do these things. For instance, I began to question why I had to continually explain to my patient population that they would need to see another provider for a number of seemingly standard services they were requesting. To make matters worse, I was losing money by not performing them! It all came to a climax on the day that I came home and asked my husband why I didn't do tubal ligations. His answer was simple. He looked at me and said, "You need a new job."

It had been my life's desire to practice in a place that simply attracts patients for its life-affirming and dignified care of women. I had longed for a practice that does not muddy the water of patient care with any pressure to contracept. More than anything, I had desired to have a mission, to be sent with a purpose. Honestly, I think a little bit of my mother's feistiness still lives within me, her beautiful willingness to fight for what is right. Thus my husband and I finally found my current practice. I feel like so many things in my life were leading me towards it, and it has really helped me and my husband renew our mission of being pro-life in every aspect of our lives and practice. Simply put, we are free to be what God has called us to be. Everyone at Bella feels the same.

Dede Chism, Bella Natural Woman's Care

To begin my own story of choosing private practice, I would like to quote Fr. Gerald Fagin, SJ, whose discussion of the teachings on reverence of St. Ignatius of Loyola have direct relevance to our lives as providers of health care:

> Reverence is a virtue to be cultivated and practiced. It is a disposition of heart that leads us to the good in all things and draws us closer to God. Reverence brings us closer to other people and to the world around us. The reverent person notices and responds to the mystery of life and the sacredness of all things. Reverence is an atti-

> tude of dependence and humility, an appreciation of the splendor and beauty of all reality, and a longing for something greater. Reverence is a self-effacing virtue, but it implies as well a reverence for oneself as a person created and loved and chosen by God. Reverence gives voice to our desire for God, our desire to find fulfillment beyond ourselves in the mystery that embraces us.[1]

It is in the spirit of reverence and this *disposition of our heart* that allows the Holy Spirit to move us. It is this disposition that, for many providers, allowed an openness of the heart to hear the movements of the Holy Spirit to respond in caring for others through the discipline of medicine.

Having worked as a Nurse Practitioner in Maternal Fetal Medicine for 20 years, the comfort of "riding out" my very good job to retirement was very attractive. Yet, having a heart that truly desired God's love and HIS plan for my life, my daughter and I stood in the High Andes of Peru and felt the movements of the Spirit. We heard the words that the brokenness of women is everywhere. He was asking us to leave our comfortable jobs and open a practice at home in Colorado where we could bring HIS love, HIS reverence, HIS dignity to each of His loved ones.

The enormity of the request was only out-shone by its clarity. He was asking us to trust. Trust like a child. He would provide everything we needed, but this had to be HIS, not ours. This was our first lesson in the blessings of letting God be in charge. When we turn our world, our jobs and our very selves to the Lord to do as He wills, there is a freedom that simply allows you to trust even more. *"For my yoke is easy and my burden is light." Mt 11:30*.

Dr. Leonard, Morning Star OB/GYN

My own call to start Morning Star OB/GYN began long before we opened in September of 2005. From the beginning, I was committed to living out the Church's teachings in my vocation, whatever it might be. Mary played a special role in this vocational discernment to be an obstetrician/gynecologist. I was in Washington, D.C., doing a medical student rotation at Tepeyac OB/GYN under Dr. Bruchalski. While there I made a visit to the Basilica of the Immaculate Conception. *It was there I realized that I would have the protection of the Blessed Mother if I entered this specialty geared towards the care of women*. Mary was a source of consolation for me during my final years in medical school and residency training and as I began my private practice as a physician faithful to the teachings of the Catholic Church. It was to honor her that I chose the name Morning Star, an ancient title for her.

At Morning Star OB/GYN, we recognize that Mary points the way to Christ, the Divine Healer. We hope to follow her example of courage, humility and fidelity in our practice and to bring the healing ministry of Christ to our patients and their families.

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[1] *Putting on the Heart of Christ: How the Spiritual Exercises Invite Us to a Virtuous Life*. Gerald M. Fagin, SJ.

Spiritual Standards and Considerations – Staying Strong Through Daily Difficulties

Dede Chism, Bella Natural Woman's Care

Choosing His way is the path to Heaven. "Right, but how do we run a practice with this mind?" By keeping it simple. Reverence. We have to have reverence for ourselves, for our staff, for our patients, for our vendors, for the hospitals with whom we work, for our accountant, for our families. For reverence to be cultivated it must be practiced; and this begins in the discipline of daily, reverent prayer in which we cultivate reverence with the God that created us, knows us, and really knows our weaknesses. From this state of humility, our practice of reverence will bring joy and the peace that surpasses understanding. We bring all our worries to the Lord and let Him sort out the details for HIS practice.

If the Lord knows every hair on our heads, He certainly is not shocked by the details of running a practice. If the missions of our practices are grounded in Him, and we use our mission as our meter on every decision, we will be on the right track. But sometimes – well, most of the time – things are changing. Whether that be insurance payors, medical suppliers, staff turnover, unexpected outcomes, or personal illness, the change can drain our strength and our spirituality wavers.

St. Ignatius describes the times we are not feeling comforted in God's love as spiritual desolation. An important rule is that we never make big decisions when we are in spiritual desolation. Now as providers, of course, we make big decisions, life and death decisions as part of our work. During this time, we stick to the TRUTH of what we know – God loves us, even if we can't feel it. So, we must continue in our prayer, even if we don't want to. We must continue in our reverence for all, even if it doesn't feel authentic. We make our decisions for our practice and our patients based on what we know to be correct. This isn't the time to try something new.

One of the greatest spiritual struggles that comes with a prolife practice is the spiritual battle that we cannot see. There is GOOD and there is EVIL, and *the Evil One desires our failure. He will go to pretty extreme measures to discourage us and to taunt us*. This may be through colleagues in the mainstream medical world; this may be through poor reimbursements and being financially stretched; this may be through lack of balance between work and home. When things are feeling bad in your very beautiful prolife practice, it is time to stop, take stock of the source, and reclaim your work and your practice in the Name of Jesus.

God is never outdone in generosity. The blessings we receive from living in His plan and serving Him in our prolife practices surpass all struggles. The disposition of our heart is a GPS for your day and for your life. Abiding in Christ allows the Spirit to move us and grow us into all that we can be; and, most importantly, grow us closer to God – living in His gaze, longing for Eternity with Him, and praying that until that time we may serve through Him, with Him and in Him. This is the key spiritual direc-

tion that aligns us in our work and invites us to bring him into even our medical and business concerns.

Medical Standards and Considerations

Dr. Bauer, Bella Natural Woman's Care

Board Certification and Field Research

I am currently board certified and have to maintain my board certification, just like any other OB/GYN in the country. Despite the challenges of interacting with the larger field, this does not change that we need to practice according to the highest standards every day in our office—in patient care, staff relations, and business practice. In fact, I believe that *the decision to be a physician carries with it a commitment to be current in most relevant science and recommendations*. We recognize that some governing bodies have recommendations that we cannot morally and ethically follow. But the vast majority of what we do in caring for women and their families remains comparable from physician to physician in so many ways. This is where the research of our colleagues can help guide the best practice for our patients. As we address the practicalities of standards, we must hold on to our moral obligations to be the very best we can be. This means staying current on journals and research, attending conferences and medical meetings and utilizing tools such as uptodate.com to bring the most relevant information to the bedside.

Dr. Bruchalski, Tepeyac OB/GYN

Our Relationship to the Hospital

As you consider a pro-life private practice, you should carefully choose the hospital where you will be delivering and operating. Tepeyac's doctors enjoy privileges to deliver at Inova Fair Oaks Hospital in Fairfax, VA. Fair Oaks offers patients an individualized experience, with a sleeping chair for a family member to stay overnight in patients' room, lactation support, and a willingness to work with midwives and doulas. Dedicated operating rooms for C-sections with a post-anesthesia care unit in labor and delivery allow mothers who have C-sections to stay with their newborns. A hospital's desire to create this kind of individualized birth experience can support tailoring the birth experience for patients from a pro-life practice.

In addition, our doctors have built a strong working relationship with the hospital by serving on hospital committees and in the hospitalist program and providing excellent patient care. Tepeyac's providers have gained the respect of other doctors at Fair Oaks through our work with them, including assisting one another with call coverage. Two of Tepeyac's doctors have served as Chairman of the hospital's OB/GYN department.

We, as doctors, are not required to perform services to which we are morally opposed, including abortions and sterilizations or to prescribe contraception for birth control purposes. The hospital works in coordination with us to allow patients to labor in an environment in which they may receive care for mind, body, and soul. We pray

with and for our patients at the hospital, and Tepeyac's patients may invite clergy to be present for spiritual support. Our patients may have doulas with them during labor. Breastfeeding support and cooperation in perinatal hospice deliveries, where the whole family can be present with a gravely ill child for the duration of that child's brief life, are other ways in which the hospital supports how we practice medicine.

Medical Moral Compromises

Often, it is the pressure to make moral compromises in medicine that leads a doctor to consider pro-life practice. I want to point the pressures out, and talk about what you might be facing as a Catholic, Protestant, or even secular pro-lifer if you are in a private practice. For example, there is pressure to:

- Refer for abortion or contraception even if not providing it;
- Give in to performing abortion when the baby had a poor perinatal diagnosis;
- Succumb to offering an unnecessary hysterectomy instead of a less simple but ultimately more restorative solution;
- Go along with inserting IUDs in teenagers, despite the clearly visible heartbreak from their poor sexual behavioral choices;
- Recommend IVF, surrogacy, or artificial insemination as a fertility "treatment";
- Look the other way when the office announces it will no longer accept needy Medicaid patients; and
- Keep the emphasis on the bottom line, even when it means less of a personal touch with each patient.

If this pressure drives you to the point of compromise, many of us have been there. Before my spiritual conversion, I did all of the above and far more. I want to let you know that you have options, and private practice is one of them.

Business Standards and Consideration

Christine Accurso, Morning Star OB/GYN

Morning Star Obstetrics and Gynecology was founded in Gilbert, Arizona, as a for-profit private practice in September of 2005 by Dr. Clinton Leonard. This mission-driven medical practice has successfully cared for patients while remaining faithful to all of the teachings of the Catholic Church. Today, we will share a few points of how we operate (and how we have navigated challenges) in hopes for others to see that it is possible to have a pro-life private practice.

Staffing

We hire all of our staff members first for the mission of the practice, and then based on their skill set and experience. Together, our team approach helps us in being faithful to our mission and purpose. The staff has different faith backgrounds, but all agree to uphold the mission and purpose of the practice. We have weekly staff meetings and ongoing formation and education, so that our staff can continue to perform at their best. We have two receptionists, one insurance specialist, three medical assistants, three

NFP instructors (one is also our bookkeeper), one practice manager, one ultrasound technician, three physician assistants and one OB/GYN doctor (and we are looking to add one more).

Maintaining Profitability

To be profitable, it is important to keep attention to the industry of reimbursement rates and be able to make decisions, as you go, to do what is best for the patients and for the good of the practice. An example of this, for us, would be that we have been drawing blood in the office for years, but when insurance companies stopped reimbursing for it, we inquired further. After some research and an inquiry to the state's insurance commissioner, we realized that this service would no longer be reimbursed. Since our patients did not have to go far (across the parking lot or 1 mile down the road) to the lab, we began to send them out for lab work. Of course, they loved the convenience of having it drawn in our office, but we had to balance the cost to the practice with the impact to our patients.

Hours of Operation

We have been responsive to our patient's needs by staying open over the lunch hour and offering appointments continuously from 7:30am – 5:30pm each weekday. This has helped with our availability to patients to serve them and their needs.

Billing for Natural Family Planning

Our approach to Natural Family Planning is key to our mission. We are able to offer four methods (in two languages) of Natural Family Planning in our office through private classes that are given by one of our seven staff members that are certified to teach it. This includes three instructors, three physician assistants, and our medical doctor. We do the classes individually because we bill insurance companies who offer the benefit of preventive medicine counseling for family planning purposes. Most insurance companies cover this benefit. Our Medicaid plans in Arizona only cover this cost when a credentialed provider teaches it, so we are able to bill the insurance company if our physician assistants, or our doctor, teach the class. If one of our three certified instructors (who are not credentialed) teaches the class, we are not able to bill. At this time, we are teaching NFP at no cost to the patients who have Medicaid, if a non-credentialed instructor teaches them. We are constantly balancing that cost to the practice to see if we can continue to do it in the future. This is an ongoing discernment process.

We want what is best for the patients and their families and sometimes that hits our bottom line. This is how our mission-driven medical practice operates. *Our approach to providing good medicine comes from a heart of service, not just to the poor and the vulnerable, but to everyone who needs our services.* Additionally, we partner with local pregnancy centers in the region.

I want to assure those who would be interested that it is possible to have a profitable, successful, and faithful mission-driven private medical practice.

Dr. Bauer, Bella Natural Woman's Care

Leadership of Staff

The natural role of a physician is one of a leader. So often we are not trained in the excellence of business and managing people, but in choosing to have a practice with the highest standards of excellence, we recognize this goes beyond patient care and into care of all. Patrick Lencioni describes a healthy organization as one in which its members have trust, healthy conflict, commitment, accountability and achieve results. This can only be achieved with regular meetings in which everyone is safe to share. Finding a healthy business model as a guide to great management of people brings your standards to the highest level.[2]

Will Waldron, Divine Mercy Care (Tepeyac's Fundraising Entity)

Including Fundraising in a Business Plan

When you have a pro-life private practice you face current market forces that sometimes mean bad medicine makes more money. Fundraising often becomes a part of your business plan in order to sustain yourself. It's important to educate and inspire donors and strategic local partner organizations to support your mission and understand you are sacrificing profits in order to practice in this way.

When a private practice is begun, seed money is often a necessary piece that comes from fundraising, which then might become a necessary component of your ongoing practice. Whether you are starting a new practice, adding fundraising to the business plan of an existing center, or seek to improve existing fundraising efforts, a diverse and successful development plan will have the same key elements.

First, get your mission and messaging set. What do you represent? What are you trying to be in your community? What needs are you meeting, and why do you need money to do it (market limitations, seeing the poor, staff and equipment, etc.)?

Once you know what you are saying, you have to decide to whom to say it. Accessing faith-based groups is one of the most powerful sources of potential fundraising revenue, and also potential patients. You can tweak the messaging depending on what group is being approached. It's possible that pastors, priests, and well-known community leaders can become valuable advocates for your organization and prospects for serving on your non-profit board.

Once you have community buy-in, you have to keep donors inspired and informed. This requires ongoing communications with donors, like email blasts and newsletter and social media, that keeps donors engaged, informed, and inspired. In this field, telling meaningful stories is one of the best ways to do this. The willingness to give will flow naturally out of compelling communications.

However, there are times when a direct ask is necessary. When most people think of fundraising, they think of event fundraising, like galas. This is important to build community and get the message out to large groups at once. However, a full-fledged

[2] *The Advantage*. Patrick Lencioni 2012.

development plan will use events as a springboard for year-round engagement through direct mail and through face-to-face meetings with the most loyal and highest donors. Developing personal relationships with your donors is key to expanding philanthropy. Too many organizations are stuck in an event model that is missing the powerful potential for more money that mail and meetings bring. Divine Mercy Care is happy to offer basic fundraising training to those interested in learning more about expanding their development program successfully, whether for the sake of seed money to start a new private practice, or to keep one going and growing.

Conclusion

We know there are serious practical, financial, personnel, and other kinds of concerns that prevent many from joining private practice. We have not figured out all the kinks, but we are doing it each day. Tepeyac has been doing it for almost a generation, and has inspired Morning Star and Bella to do likewise. Together, we are becoming a team, an assembled group of people who want to help those who are interested in joining or starting private practice. If private practice was a dream of yours that is reawakening in your heart, I hope you will contact Divine Mercy Care (info@divinemercycare.org) so we can direct you to the best person to answer your questions and meet your needs. We are pleased to be able to share part of our stories with you, and we hope we can share in your story as you go forward.

Healthcare and Planned Parenthood: The Significance for Pro-Life OB/GYNs

Jeffrey J. Pauls, Ph.D. and Carl Landwehr, M.A.

The findings from Vitae Foundation's seventh Right Brain research study, *Saving Grace: Examining the Planned Parenthood Brand* (2015), offer practical suggestions for helping medical professionals serve an important role in an ever-developing, integrated pro-life model of healthcare and social services. The responses of women in the study reveal both positive and negative feelings, experiences and attitudes toward the Planned Parenthood brand and the "healthcare" offered there. The Planned Parenthood strengths, to the extent possible, can be mimicked and reproduced and the weaknesses can be easily addressed within more responsible, comprehensive and professional medical practices.

Right Brain Research Methodology

The Vitae research strategy employed in these seven studies is unique as it focuses on the right side of the brain where consumer decisions are made including having an abortion. Charles Kenny, Ph.D., a consumer psychologist who has conducted research in the area of branding and marketing with companies such as American Express, Maybelline, McDonalds, Toyota and Wal-Mart, has led each of the projects. The proprietary research methodology perfected by Dr. Kenny and his Right Brain team bypasses the left side of the brain, which is the logic side, through a process of visualization, repetition, and relaxation. This process investigates the emotional needs and barriers that explain the respondent's behavior. According to Dr. Kenny, "The pictures that respondents see in their minds' eyes are emotionally significant to them. The pictures are available to them because the emotion they experienced at the time locked the visual images into their long term memories. Once respondents are viewing past experiences with the products or the service, [in the case of respondents in the *Saving Grace* study, it is their visit to Planned Parenthood] we interview them about what they are seeing and how they are feeling in the picture. This technique elicits information that is much richer and far more revealing than information produced from more traditional interview methods, because people are actually reliving the experiences they have had in the past and are in touch with the feelings that are associated with those events. Emotional research is

a powerful tool for understanding consumers, because it provides the deepest level of psychological analysis possible."[1]

Propping up the Planned Parenthood Brand

The *Saving Grace* study included 70 women (total) in New York, Miami, Chicago and Los Angeles who went to Planned Parenthood for services including birth control and abortion. The respondents included those with both a favorable and un-favorable experience. This study shows that Planned Parenthood's image as a valid health-care provider is dependent upon the support of two demographics: (1) Adolescents and (2) "Legacy Customers."

Adolescents

The adolescent group is defined by their emergence into young adulthood, and, unfortunately, engagement in risky sexual behavior. For this group, the Planned Parenthood brand promises: 1. Secrecy – adolescents are usually scared that their parents will find out they are sexually active and, 2. The illusion of empowerment to make their own decisions, be "protected," and enjoy sex without repercussions.

Additionally, adolescents believe that Planned Parenthood can help them with various reproductive health concerns but this is generally secondary to their desire to obtain birth control, which Planned Parenthood effectively manipulates to its own advantage in two significant ways. First, Planned Parenthood markets birth control extensively and effectively, relying heavily on widespread societal acceptance and societal ignorance of the often-severe and unsafe side effects and complications, especially of the most common form used by adolescents: the pill/chemical contraception (which is listed as a Group 1 Carcinogen by the World Health Organization).[2] Second, they overemphasize the effectiveness and safety of birth control, as demonstrated by the following information on the Planned Parenthood website: "Birth control is how you prevent pregnancy before it begins. There are lots of different methods that work really well and are easy to use. So, ready to stop worrying about pregnancy? We're here to help you figure it all out…Chances are the pill will be totally safe for you — most people can take it with no problems. It's been around for more than 50 years, and millions of people have used it safely…It's important to remember that for most people, the chance of having any of these problems while taking birth control pills is really, really low. In fact, pregnancy is more likely to cause serious health problems than the pill."[3]

Statements such as these are misleading by design, as Planned Parenthood has been aware of the well-established data showing extremely high failure rates of contraception

[1] Kenny, C. (2008). *The Right Brain Way.* Victoria, B.C.: Trafford, 51-53.

[2] World Health Organization. (2005) Carcinogenicity of combined hormonal contraceptives and combined menopausal treatment. Available at: http://www.who.int/reproductivehealth/topics/ageing/cocs_hrt_statement.pdf. Accessed August 9, 2017.

[3] Planned Parenthood. Available at: https://www.plannedparenthood.org/learn/birth-control. Accessed August 9, 2017.

among adolescents for decades.[4] While the normal failure rate of oral contraceptives (the most common type of birth control used by adolescents) is 5-8% in the general population,[5] it jumps to 15-26% in adolescents.[6] The failure rate for all forms of birth control rises to an astonishing 47% in adolescents who are unmarried and cohabitating.[7] Through marketing and misleading information, Planned Parenthood is able to rely heavily on birth control (and its guaranteed real life failure rate) as the gateway to their most lucrative area of "healthcare": abortion. When a girl or woman who is actively trying not to get pregnant does get pregnant, abortion becomes a very real possibility and Planned Parenthood is highly effective in "helping" her make this choice (more information can be found in the "Counseling" section).

The palatable way Planned Parenthood provides options for birth control gives young women a feeling of control over their sexual health and medical care, which helps them feel more like the independent adults they want to be. Birth control is the primary hope-giver and the one most utilized. It is primarily because of birth control's unquestioned central, positive role in protecting her current sexual health and future self, and the related masterful marketing by Planned Parenthood, that respondents in the *Saving Grace* study generally perceive the organization as a "Respectful," "Knowledgeable," and "Non-judgmental" healthcare provider which takes time to legitimize their feelings and concerns.

Finally, adolescents prefer discussing sexual health with Planned Parenthood over their primary care provider if: 1. The primary provider is a family doctor who the adolescent's parent(s) utilize, 2. The adolescent has a long-standing relationship with provider, 3. The provider is male, and 4. The adolescent does not have health insurance.

"Legacy Customers"

The Planned Parenthood brand relies on the tenuous support of a second group: "Legacy Customers," defined as women over twenty-five who refer younger friends and family members. This is a complex group which, despite often reporting negative encounters at Planned Parenthood, remains loyal to the brand, refers other women and claims to think highly of Planned Parenthood. In accordance with past Vitae studies, the reasons for the excusal or promotion of Planned Parenthood by the "Legacy Customers" are tied to psychological defense mechanisms such as rationalization, justification, and

[4] Fu, H., Darroch, J., Haas, T, & Ranjit, N. (1999). Contraceptive Failure Rates: New estimates from the 1995 national survey of family growth. *Perspectives on Sexual and Reproductive Health*. 31(2) 56-63. Available at: https://www.guttmacher.org/journals/psrh/1999/03/contraceptive-failure-rates-new-estimates-1995-national-survey-family-growth. Accessed August 9, 2017.

[5] Committee on Adolescence, American Academy of Pediatrics. (2007). Contraception and Adolescents. *Pediatrics*, 120(5) 1135-1148.

[6] Burke A.E., & Blumenthal P.D. (2001) Successful use of oral contraceptives. *Seminars in Reproductive Medicine*. 19, 313-321.

[7] Fu, H., Darroch, J., Haas, T, & Ranjit, N. (1999). Contraceptive Failure Rates: New estimates from the 1995 national survey of family growth. *Perspectives on Sexual and Reproductive Health*, 31(2) 56-63. Available at: https://www.guttmacher.org/journals/psrh/1999/03/contraceptive-failure-rates-new-estimates-1995-national-survey-family-growth. Accessed August 9, 2017.

compartmentalization. However, the *Saving Grace* study demonstrates that Planned Parenthood loses appeal as women mature, start families, engage in less risky sexual behavior and obtain jobs and health insurance. The "Legacy Customers" have higher expectations for level of care and comfort. They develop more of a consumer mindset about their medical care. They tended to have a much higher likelihood of going to, and a more positive outlook toward, a family doctor or OB/GYN.

The Planned Parenthood Healthcare Message

The study, demonstrated that women who have abortions at Planned Parenthood do not refer to abortion as curing a disease or treating an illness. The reasons given for abortions were socio-economic and familial. As Planned Parenthood-loyal customers, they cling to the notion that the organization provides "sexual health services", but not necessarily all of a woman's health needs. They tend to understand and portray Planned Parenthood as a specialized "sexual health" clinic, one that does not provide total woman's health care services (although many say they do not necessarily expect it to, nor need it to).

The Future Self

In earlier studies, it was discovered that women seek abortions to restore their current self and protect their future self. The current self is typically referred to as a lifestyle or career. The future self is what the young woman anticipates her career or lifestyle will be like as she matures. In yet other studies, it was discovered that many women, even young teenagers, write a life plan. As they mature, they live out the life plan that they wrote as young girls. Consequently, the current self and the future self are extremely important, and women will go to great lengths, even so far as having an abortion, to protect both.

The 2015 study offers information about an additional future self which is holistic, healthy, and happy, seen tacitly as a desire for happiness, self-respect, admiration, freedom from guilt, physical and mental health, and essentially a state of emotional well-being. For many women, abortion destroys this future happy or joyful self for many years, if not her whole life. Abortion, according to many respondents in the *Saving Grace* study, did protect their material future selves (education, career, lifestyle) but the many instances and examples of compartmentalization, justification, rationalization and minimization demonstrated that most of the women were still dealing with a lasting negative impact on their joyful (happy, healthy, holistic) selves many years or decades after their abortion(s). Perhaps another way to describe this important point is that abortion seemingly puts a woman's current life "in control" but nearly always leaves her future life out of balance in many important health-related ways. Planned Parenthood works diligently and effectively to convince the women that abortion will make everything "all right" but the findings in this study (and several previous ones) make it obvious that the vast majority of women are never the same.

Whole Person Wellness

These findings can be more fully understood by juxtaposing them with a full and comprehensive definition and description of health and wellness. Indeed, the very definition of optimal health, in a full, modern context, as defined by the *American Journal of Health Promotion* is "a balance of physical, emotional, social, spiritual and intellectual health."[8] The World Health Organization defines health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity."[9] These definitions are expanded, supported and best represented by the idea of Whole Person Wellness, developed by Jan Montague and consisting of six key dimensions of health, including physical, social, spiritual, emotional, vocational and intellectual.[10] This work is implemented and well-represented at the Center for Aging, California State University-Fullerton.[11] The pioneering work in Whole Person Healthcare ™ and Whole Health Education ® by Dr. Georgianna Donadio,[12] founder of the National Institute of Whole Health in Boston, Massachusetts[13] also supports this finding. The Duke Center for Integrative Medicine is a current leader in applying the ideas of Whole Person Health into what is labeled "Integrative" Healthcare.[14] This well-established medical field, as a whole, is analyzed, evaluated and overseen by the National Center for Complementary and Integrated Health (NCCIH), under the National Institutes of Health, within the U.S. Department of Health and Human Services.[15]

Given the best practices of the healthcare profession today, Planned Parenthood falls far short of providing customers with Whole Person Wellness and Healthcare, consisting of the six vital components: physical, social, spiritual, emotional, intellectual,

[8] O'Donnell, M. (2009). Definition of Health Promotion 2.0: Embracing Passion, Enhancing Motivation, Recognizing Dynamic Balance, and Creating Opportunities. *American Journal of Health Promotion*, 24 (1), iv-iv; updated from Michael P. O'Donnell (1986), Definition of Health Promotion, *American Journal of Health Promotion*, June 1986, 1 (1), 4-5. Available at: http://www.healthpromotionjournal.com/index.php. Accessed August 9, 2017

[9] World Health Organization. (2006). *Constitution of the World Health Organization – Basic Documents*, Forty-fifth edition, Supplement, October 2006.

[10] American Senior Fitness Association. Available at: http://www.seniorfitness.net/Wellness%20Solution.htm. Accessed August 9, 2017.

[11] California State University, Fullerton, Center for Successful Aging. Available at: http://hdcs.fullerton.edu/csa/WholePerson/about.htm. Accessed August 9, 2017.

[12] National Institute of Whole Health. Available at: http://www.wholehealtheducation.com/whole-health-programs/courses-videos/georgianna-donadio/. Accessed August 9, 2017.

[13] National Institute of Whole Health. Available at: http://www.wholehealtheducation.com/. Accessed August 9, 2017.

[14] Duke Integrative Medicine. Available at: https://www.dukeintegrativemedicine.org/about/. Accessed August 9, 2017.

[15] U.S. Department of Health and Human Services, National Institutes of Health, National Center for Complementary and Integrative Health. Available at: https://nccih.nih.gov/. Accessed August 9, 2017.

and vocational health.[16,17] Planned Parenthood only superficially treats several of these components and does not treat at all the emotional needs of the patient either in the short or long term. Planned Parenthood does not do adequate pre- or post-abortion counseling to address the damage done to many women, especially in the areas of emotional, social and spiritual health. If they were to offer post abortion counseling, it would be an admission that abortion causes harm to women. Planned Parenthood rarely treats the women physically or emotionally after the abortion, leaving that to nearby emergency rooms and professional counselors. Planned Parenthood simply makes the woman un-pregnant, and after the abortion sends her back to a risky and dangerous social environment that enhances the likelihood of another pregnancy. It can easily be concluded from the research that healthcare defined by Planned Parenthood is merely a marketing term with no meaningful application to the social, emotional, and spiritual needs of women who have an abortion at Planned Parenthood.

It should be noted that we did not seek or obtain data on whole person health and wellness or integrative health through the *Saving Grace* study but simply took the data and findings produced by the study in the area of healthcare, or more appropriately, the lack thereof, at Planned Parenthood and compared what we heard participants say with the established best practices in the medical field. The number and type of alarming responses from women in the study that reflected a lack of care, using any accepted modern medical standard, but especially when viewed within the broader, more comprehensive Whole Person Health and Wellness approach, is an important understanding and a significant area of focus going forward.

Medical Misinformation

Additionally, Planned Parenthood can be easily criticized from an ethical healthcare perspective. When advising women facing unexpected pregnancies, Planned Parenthood denies the humanity of the unborn child (not to do so would negatively impact their profit margin) which forces the organization to either avoid the topic or to use scientifically inaccurate descriptions of the fetus and unborn child as a "product of conception," "glob of cells," or "mass of protoplasm," even at later gestational ages. Such terms contradict basic, foundational definitions and terminology established and used by the scientific and medical fields. Planned Parenthood also acts in direct opposition to the basic understanding of the medical community of the right to healthcare by even the tiniest of patients. Advancements in modern medicine to perform in-utero surgery to correct heart, brain, and lung defects (along with the proper administration of pain medication to these tiny patients) stand in contrast to the practices that Planned Parenthood attempts to classify as "healthcare." These types of practices are oppositional to the best practice of healthcare professionals.

[16] American Senior Fitness Association. Available at: http://www.seniorfitness.net/Wellness%20Solution.htm. Accessed August 9, 2017.

[17] Art and Science of Health Promotion Institute. Available at: http://www.healthpromotionjournal.com/index.php. Accessed August 9, 2017.

"Counseling"

A discussion of what respondents said about Planned Parenthood's "healthcare" services would not be complete without describing an important aspect of the "counseling" that Planned Parenthood provides women who are considering abortion. Throughout the interviews, women described and complained about the lengthy intake survey they were required to complete during their equally lengthy waiting room experience. Vitae analysts speculate that this survey tool is used to exacerbate the woman's fears and undermine her ability to carry her child to term. Women describe Planned Parenthood "counselors" bringing up alternatives to abortion but in ways that actually made them more likely to abort (subtly revisiting and affirming the fears, barriers, challenges and concerns they listed on the intake survey, which includes a comprehensive list of such questions and prompts). Of course, this is opposite of what Pregnancy Help Centers do to honestly and directly identify and alleviate a mother's fears and to address the life challenges that may prevent her from feeling like she can carry her pregnancy to term or succeed in other areas of life.

Strengths of the Planned Parenthood Brand

The strengths of the Planned Parenthood brand can easily be replicated. Once understood and placed within the more appropriate contexts of professional, caring, competent approaches of pro-life OB/GYN's, these strengths can be exponentially magnified. It should be noted that most of the following strengths are already being practiced by pro-life doctors but a greater emphasis, awareness and intentionality regarding marketing to, and communicating with, especially younger, adolescent patients (but also to their parents and/or the "legacy customers" in their lives) would likely have a positive influence on patients and the way they see pro-life doctors.

The strengths of the Planned Parenthood brand are manifested through repeated responses related to the following five areas, all of which are tied to Planned Parenthood helping women develop a false "sexually-active-but-responsible" self-identity:

1. *Specialization*. Although Planned Parenthood may not offer comprehensive medical care, it offers everything a young woman (especially one without insurance) feels she needs in terms of sexual health. Respondents often go to Planned Parenthood because they are afraid for their "sexual health." They feel that Planned Parenthood is a legitimate place to go for common health problems of that nature.
2. *Professional medical setting*. Planned Parenthood exceeds early expectations of quality and extent of service and treatment (which are often low if she has not had access to quality medical care or, again, if she does not have insurance). Respondents report normal medical protocol, such as being weighed and getting blood pressure done, which make them feel they are in the hands of people who are concerned about their health.

3. *Confidentiality*. This is the biggest concern of young women, who are attempting to keep their risky sexual activity a secret from their parents or guardians while simultaneously exhibiting independence and growing into adulthood. The word or idea of "confidentiality" pervaded the responses in the *Saving Grace* study but respondents' description of what they liked about Planned Parenthood often revealed the more accurate terms to be "secrecy", "approval" and "license." Despite using inexact language, they understand confidentiality can be found at any professional medical office but know they can't expect secrecy, approval or license. This might be the most challenging area for pro-life OB/GYNs, in terms of replicating the strengths of Planned Parenthood. Since the above terms/ideas are not part of responsible and ethical best practices of medical care (nor are two other areas that pro-life doctors avoid: abortion or ubiquitous prescription of Group 1 carcinogens) and, yet, respondents in the study universally acknowledge the desire for such services and comportment from doctors and/or medical staff, pro-life OB/GYNs must be able to promote real confidentiality and a subtle yet powerful educational approach to understanding the beauty, power, and functionality of a healthy female reproductive system. A modern presentation of Fertility Awareness Based Methods (FABM)[18] connected to ideas associated with the "green"/organic movement, whole person health and wellness, Theology of the Body,[19] and helping women to understand that fertility is not an adverse medical condition are ways that can be used to accomplish this with young women who likely have never heard this perspective and would be open, interested and even excited to hear about it.
4. *Nurturing female staff*. The abundance of female staff at Planned Parenthood is something respondents appreciate and seem to associate with increased acceptance, understanding and empowerment. Planned Parenthood staffers and volunteers often share their own experiences with birth control, abortion or reproductive care and respondents describe female medical staff as conversational and casual during exams.
5. *Education*. Respondents feel that Planned Parenthood helps them control their lives with knowledge about practices related to sex, responsibility, and "protection." Some respondents take health information seriously for the first time from Planned Parenthood, after ignoring their parents and health classes. The pamphlets on various topics littering Planned Parenthood give respondents easy access to information which helps them feel in control because they can assimilate the knowledge on their own terms.

[18] Manhart, M.D., Duane, M., Linda, A., Sinai, I., & Golden-Tevald J. (2013). Fertility awareness-based methods of family planning: A review of effectiveness for avoiding pregnancy using SORT, *Osteopathic Family Physician,* 5(1), 2-8.

[19] Theology of the Body Institute. Available at: http://tobinstitute.org/. Accessed August 9, 2017.

Weaknesses of the Planned Parenthood Brand

Weaknesses of the Planned Parenthood brand can be (and often already are) easily addressed within more responsible, comprehensive and professional medical practices. Therefore, the below weaknesses are presented primarily for informational purposes but may have some practical implications for pro-life OB/GYNs as well.

At Planned Parenthood, symptoms of reproductive issues are treated (usually with birth control), but the causes are not addressed. Planned Parenthood has a distinctly limited scope of what they can do. Referrals are often lacking, or not nearly diligent enough. There is a sense of mistrust with Planned Parenthood when a certain "level" of care is required. Additionally, when respondents suffer from complications (especially common after chemical abortion), the follow-up and care given seems sorely lacking. It appears to respondents as though once the abortion is done, the level of care and concern declines noticeably. However, Planned Parenthood is not seen as a place that provides all of the women's health needs. It serves primarily as a specialized clinic for women who need sexual health services. Some women prefer using Planned Parenthood to a regular gynecologist for more sensitive issues or sexual issues they want to keep more secretive. Hence, as they grow older and the need for secrecy about sexual matters abates, most outgrow Planned Parenthood entirely.

Implications for Pro-Life OB/GYNs

Based on the information presented here, there are a number of practical steps for pro-life OB/GYNs to take. The first is to continue to become familiar with this unique area of research:[20] the psychological and emotional responses of women toward abortion (generally) and the psychological and emotional state of a woman facing an unexpected pregnancy (specifically). The second is to ensure all messaging, marketing and direct patient communication meets the needs of such women and doesn't unintentionally push them toward Planned Parenthood. The third is to include pamphlets, flyers and informational materials related to PHCs, FABM, whole person health and wellness, etc. in the waiting room. This is an influential, yet low-pressure, indirect way to reach women coming to OB/GYN appointments. Finally, pro-life OB/GYNs can establish cross-referral systems with Pregnancy Help Centers, allow qualified, vetted, local PHCs (who may not have their own medical capacity) to refer patients to them, or work directly with PHCs, either as consultants, volunteers, employees, medical directors or board members. Additionally, there are rapidly expanding professional opportunities at comprehensive women's health centers such as Bella/Marisol,[21] Guiding Star,[22] Obria,[23] Stanton,[24] and

[20] Vitae Foundation. Available at: http://vitaefoundation.org/about. Accessed August 9, 2017.

[21] Bella Natural Women's Care and Family Wellness. Available at: http://www.bellanwc.org/. Accessed August 9, 2017

[22] The Guiding Star Project. Available at: https://theguidingstarproject.com/. Accessed August 9, 2017

[23] Obria Medical Clinics. Available at: https://www.obria.org/medical-services/. Accessed August 9, 2017.

[24] The Stanton Project. Available at: http://www.thestantonproject.org/. Accessed August 9, 2017.

Tepeyac.[25] These comprehensive, pro-life medical centers are growing in number, reach, effectiveness, and familiarity within communities across the United States.

Conclusion

Because we know that abortion does not cure a disease or treat an illness, what Planned Parenthood does in the name of "healthcare" harms women through widespread physical, mental, social, emotional, spiritual and ethical[26] complications that result from abortion. Planned Parenthood only makes a woman un-pregnant and sends her back to a dysfunctional social environment. It's an organization that does not follow current healthcare "best practices." The *Saving Grace* study, conducted with loyal Planned Parenthood customers, demonstrates the importance of what pro-life OB/GYNs do in offering an alternative to Planned Parenthood.

The marketing themes of the abortion advocates change every fifteen to twenty years. The most recent change was a shift from "choice" to "healthcare." If Planned Parenthood is able to take abortion in the direction that birth control has gone over the past 50 years, making it more palatable to the American people, Vitae analysts expect Planned Parenthood's marketing to shift again, from "healthcare" to "duty" – "it's a woman's duty to have an abortion" if she meets any of a long list of possible conditions or situations. However, the pro-life medical community, through the practice of authentic, responsible, professional healthcare in tandem with improved research-based marketing, messaging and communication methods will be able to effectively compete with Planned Parenthood and eventually put them out of business. A superior and more responsible approach as outlined by two vital parts of the ancient Hippocratic Code ("First do no harm; I will maintain the utmost respect for human life, from the time of conception."),[27] backed by the truth and carried out in love and service, remains the best way to do so.

[25] Tepeyac OB/GYN. Available at: http://tepeyacobgyn.com/. Accessed August 9, 2017.

[26] Patil, A., Dode, P., & Ahirrao, A. (2014). Medical ethics in abortion. *Indian Journal of Medical Practice*, 25 (6), 544-548. Available at: http://medind.nic.in/iaa/t14/i11/iaat14i11p544.pdf. Accessed August 9, 2017.

[27] *Ibid*.

Abortion-Breast Cancer Link (ABC Link): Review of Recent Evidence from Asia

Joel Brind, Ph.D.

The first published evidence for the ABC link came from Asia 60 years ago. That's when a nationwide study in Japan showed a relative risk of 2.6; a 160% increase in breast cancer risk among women who'd had at least one induced abortion.[1] My group's "Comprehensive Review and Meta-analysis of worldwide data,"[2] published by the British Medical Association in 1996, reported an average relative risk of 1.3 (30% increased risk. The difference in magnitude of the relative risk is traceable to the difference between a risk-increasing exposure (e.g., abortion) acting in a low breast cancer incidence population (e.g., 20th century Japan), and a high incidence population (e.g., the Western industrialized world since the 1980s).

In round figures, induced abortion adds about a 3% absolute lifetime risk to women everywhere. In the West, a relative risk of 1.3 raises the lifetime risk from about 10% to about 13%, and in the developing world, from about 2% to about 5%. Over the last 10 years, 20 studies have reported data on the ABC link in South Asian women (i.e., from India, Pakistan, Bangladesh and Sri Lanka).[3] South Asia is a region wherein the typical woman marries while in her teens, begins having children early, has several of them, breastfeeds all of them, doesn't smoke and doesn't drink alcohol. Hence, contraceptive steroids and abortions are the only exposures among classical risk factors at play. Breast cancer incidence is therefore low (about 2% cumulative lifetime risk), and a relative risk for abortion would need to be about five-fold higher in such a population (as in Japan in the 1950s) to show the same effect as in the Western world.

The low magnitude of the risk identified worldwide led to the hypothesis that it was an artifact due to reporting or response bias,[4] and that any real risk increase would have to show up in prospective data-based studies. The response bias hypothesis postulates that in the collection of retrospective data for a case-control study, women who have breast cancer will be more likely to disclose prior abortions, compared to healthy women. Hence, the same prevalence of abortion in case and control groups, but a higher *reported* prevalence among cases, would show up as an artificially positive—rather than a null—association. It is unarguable that a study based on prospective data is not subject to reporting bias, since ascertainment of exposure status (abortion) necessarily

antedates that of disease outcome (breast cancer). Hence, it is argued that studies based on prospective data are superior to retrospective-data-based studies (typical case-control studies),[5] but this is only true if the studies are equally sound otherwise.

A steady stream of prospective studies was then published between 1997 and 2008, in the highest impact journals.[6-14] These studies all showed no increased risk of abortion in women from the US, UK, Europe and China (where the "one-child policy" had made abortion highly prevalent), and fueled the continuing denial of the ABC link by "mainstream" health information outlets (ACOG, RCOG, WHO, NCI, etc.).

By far the largest and most notorious of these studies was the 1997 cohort study on women in Denmark by Melbye et al.,[6] funded by the US Dept of Defense and published in the *New England Journal of Medicine*. Since the Melbye study was based on medical records of abortion on 1.5 million Danish women, among whom were performed over 370,000 abortions and were diagnosed over 10,000 cases of breast cancer, their reported overall statistic of relative risk of 1.00; 95% CI: 0.94 – 1.06 has been widely touted as virtual proof of a null association. Several smaller European and US studies also subsequently reported similar results between 1997 and 2008, bolstering this claim. All of these studies, however, have come under serious criticism for a host or methodological defects, including frank violations of the scientific method.[15-27] For example, the study of Melbye[6] had misclassified over 60,000 who had had one or more induced abortions, as not having had any abortions, their records having been inexplicably excluded from the available records of abortion exposure. This massive misclassification alone renders invalid the summary overall statistic of a null association and its very tight 95% confidence interval. Moreover, the ascertainment period for both exposure and outcome ended on the very same date, thus allowing for as little as zero follow-up time for the exposure to produce the putative outcome; plainly an absurdity. Adding to the absurdity is the fact that over one fourth of the cohort (i.e., 358,000 women) were actually under the age of 25 at the termination date of the study; which allowed the inclusion of tens of thousands of abortions among a portion of the population among whom were diagnosed fewer than 10 cases of breast cancer. Yet the most obvious violation of the scientific method by Melbye et al.[6] was the use of an exposure (induced abortion) database that began in 1973, linked to the outcome (breast cancer) database that began in 1968, as if outcome could precede exposure!

The violations of proper scientific methodology are many and varied. In addition, a "collaborative reanalysis" of prospective and retrospective data appeared in the *Lancet*[5] in 2004, which meta-analysis also purported to show no ABC link. Yet this review also employed illicit methodology, specifically, the exclusion of many studies for inappropriate reasons, such as:

1. "principal investigators…could not be traced"
2. "original data could not be retrieved by the principal investigators"
3. "researchers declined to take part in the collaboration"

4. "principal investigators judged their own information on induced abortion to be unreliable" (even though it had been vetted by peer review and published in a prominent medical journal).

Our earlier "comprehensive review and meta-analysis" on the ABC link worldwide,[2] stated in 1996 that the extant worldwide literature had already demonstrated "a remarkably consistent, significant positive association between induced abortion and breast cancer incidence, independent of the effect an induced abortion has in delaying first full term pregnancy." Importantly, if this conclusion was correct, the impact on breast cancer incidence should be clearly evident by now, over 20 years later. This is especially true considering the worldwide expansion of legalized abortion during the late 20th century and the latency in the development of breast cancer. In fact, evidence abounds that supports this conclusion, especially as elective abortion has played its part in the "Westernization" of cultures in the developing world, such as in Asia. In regard to mainland China, for example, Linos et al.[28] stated unequivocally in 2008: "China is on the cusp of a breast cancer epidemic." By 2013, Huang et al.[15] had amassed 36 primary studies in China in their systematic review and meta-analysis (SRMA). They reported a statistically significant 44% increase in breast cancer incidence associated with induced abortion, which risk increase rose with the number of abortions (76% for two or more abortions and 89% for three or more abortions) among Chinese women.

But in addition to the reporting/response bias argument against the positive association emerging from retrospective data-based studies worldwide, data emerging from several studies in Shanghai, China, both retrospective[29,30] and prospective,[9] have also shown a null association between induced abortion and breast cancer. The consistency of this finding and the very large populations under study have been used to bolster the reporting bias hypothesis. But in the Huang meta-analysis, the authors explain that the lack of a positive association in places like Shanghai—where the prevalence of abortion is very high—had been explained by myself and Chinchilli in a 2004 letter to the British Journal of Cancer,[22] wherein we wrote:

> Once the prevalence of a given exposure rises to a level of predominance, it is prudent to ask whether indeed the unexposed comparison group has instead become a subgroup, which is unexposed for some reason that bears relevance to its risk profile for the disease in question. In such a case, statistical adjustment cannot remove all such confounding, since the calculation of the adjustment term will necessarily be underestimated.

In terms of breast cancer, those with no abortions are more likely those who are less fertile, and/or have their first full-term pregnancy (FFTP) at a later age, thus constituting a sub-group at higher risk than the general population without abortion.

Huang et al.[15] also showed how this explanation "was well exemplified by the meta-regression analysis in our study." In their meta-regression curve the meta-regression line crosses the line OR = 1 at approximately 69% prevalence of induced abortion among controls. Hence, the observed OR of earlier Shangai studies[29,9] wherein the observed prevalence of induced abortion among controls was 66% and 51%, respectively, was

not significantly different from 1.0. This is clearly shown also by plotting the results of a subsequent study from Shanghai by Wu[30] et al. (where the prevalence of abortion among controls was 70.5%), a 1979 study from Yugoslavia[31] (where the prevalence of abortion among controls was 72.5%) and a recent study from Serbia[32] (where the prevalence of abortion among controls was 80%), on the Huang et al.[15] meta-regression graph. For the latter two studies, the results are predictably in the range of a negative association—an apparent protective effect—of induced abortion re: breast cancer risk, because the prevalence of abortion is so high. Such results merely demonstrate that populations in which the majority of women have had at least one induced abortion, are unsuitable for studying abortion as a risk factor for breast cancer.

Figure 1

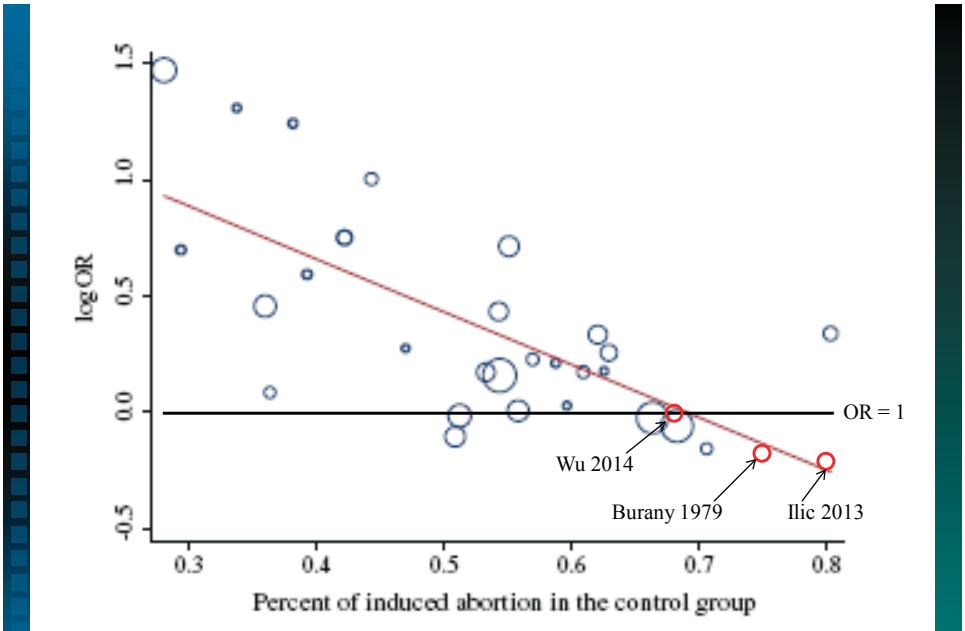


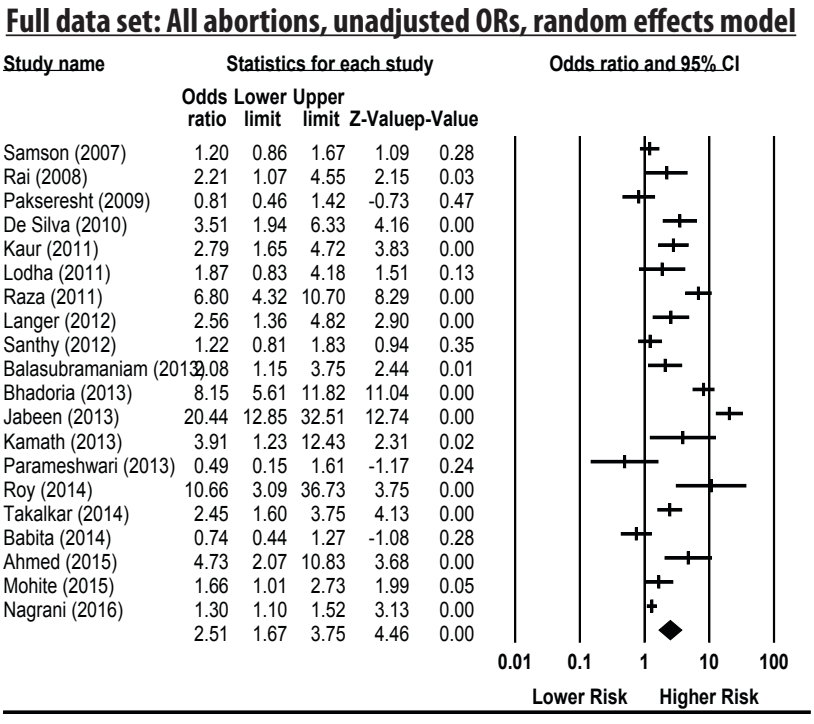
Fig. 6 Meta-regression of percent of IA in the control group with odds ratio of individual study

In contrast, South Asia, where the prevalence of induced abortion is still relatively low (and much lower in rural, compared to urban women), provides an eminently suitable population for the study of this putative association. In our new systematic review of South Asian studies,[3] we found 20 primary studies reporting ABC link data this century, all published within the past 10 years. The forest plot shows a relatively strong ABC link: Odds ratio (OR) 2.51; 95% CI 1.67 – 3.75. Two of the studies actually report relative risks (ORs) >10.

In addition to the overall significant positive association found among South Asian studies, a clear, highly significant ($p < 0.0001$) dose effect also emerges: All 5 studies

which stratified data by number of abortions show the same trend of increasing risk with increasing number of abortions. Dose dependence is one of the key criteria employed in drawing a causal inference from observational epidemiological data.

Figure 2



An interesting aspect of the South Asian dataset is the fact that most studies do not report specifically on induced and spontaneous abortions, but just on "abortion," thus including both types. Since spontaneous abortion does not increase breast cancer risk, the overall result can actually be presumed to underestimate the real relative risk, as induced abortion represents only about half of total reported abortions.

But the reason for the combination of induced and spontaneous abortion is the stigmatizing effect of induced abortion, so researchers generally opt not to ask about induced abortion specifically. Curiously, this seems to have led to actual cases of reporting bias—but in the direction of *underestimating*—rather than overestimating—the relative risk. Specifically, there are examples among the South Asian studies wherein there is more missing abortion data for cases, rather than controls. This appears to be because of potential subtle coercion to participate in the study of eligible cases. That is, many studies report 100% participation among eligible cases, and it may be that breast cancer patients feel that their care may be compromised by their refusal to participate in the study. Then, when it comes to answering the questions about abortion on the

study questionnaire, they simply do not provide the data. But the control selection is much easier, since there are always plenty more potential controls than cases to recruit for the study. Often, they are outpatients or healthy women being seen for screening or unrelated issues, so it is easy for them to say no. In such a situation, abortion reporting is likely to be more accurate for controls, whereas cases will "underreport" their abortion history, resulting in an underestimation of the real relative risk.

But just as the politicization of the ABC link in the Western medical literature has resulted in widespread denial, there is evidence that some of the same actors have spread their malevolent influence eastward.

The largest, most recent and ostensibly most well designed of the South Asian studies is that of Nagrani et al.[33] As this study is about an order of magnitude larger than most of the other studies, it has the most weight in the overall meta-analysis. Moreover, it is the only study that reported on induced abortion specifically and adjusted the ORs for a number of potential confounders and stratified by number of abortions. It is therefore noteworthy that Nagrani et al. also reported the lowest overall OR for induced abortion (OR 1.30; 95% CI 1.11 – 1.53, pooled from the separate ORs they reported for urban and rural populations). Yet there are several aspects of the Nagrani paper which are very unusual and may serve to explain its somewhat discordant results in terms of bias and/or confounding.

The selection of patients from Tata Memorial Hospital in Mumbai in Nagrani et al. appears straightforward, but there is no direct indication as to how many of the patients and controls were nulliparous. Instead, parity is reported in 4 strata of "No. of full-term pregnancies": 1 (reference stratum), 2, 3 and 4 or more. This is odd, since all other included studies included nulliparous women in their calculations of the effect of parity. Hence, it was necessary to calculate the number of nulliparous women in the Nagrani study indirectly, by subtracting the numbers of urban and rural patients and controls reported as having had any full-term pregnancies, from the numbers of urban and rural patients and controls in the total population. The results of these calculations are quite striking, in two ways. First, there is a more than three-fold difference in the nulliparity rate between urban and rural subjects (approximately 8% urban v. approximately 2.5% rural). Secondly, there is no significant association between nulliparity and breast cancer, whereas the observation of a positive association is well established and practically universal,[34] among South Asian studies as well. If anything, nulliparity appears somewhat protective in the Nagrani et al. study, especially among rural women (although the number of nulliparous rural women is very small). It is possible that the unusual results re: nulliparity are related to the unusual way in which the controls were selected.

Controls were selected from among cancer-free "female visitors…who were accompanying cancer patients." No doubt many of these visitors were related to the patients they accompanied, and this could be expected to affect the results of various comparisons. For example, even though family history of breast cancer is well estab-

lished as a risk factor for breast cancer, family history shows up in the Nagrani study as a protective factor, with 4.1% v. 8.3% of urban cases and controls, respectively reporting a positive family history of breast, endometrial or ovarian cancer. But this negative association should be expected, considering that every control subject who is related to a study patient has a positive family history of breast cancer, by definition. Yet the authors make no mention in the text of family history at all, let alone of this anomaly that shows up in the data table.

Yet stranger still, controls "were frequency matched to cases based on age (+/- 10 years)." Such a large age range as a matching window is unheard of in studying any disease with a steep age-incidence curve as is breast cancer.[35] Hence, the significant difference ($p = 0.007$ for urban and rural subjects combined, by t-test) in the (younger) age profile of controls compared to patients, serves to lower the observed association with induced abortion. Moreover it is troubling that Nagrani et al. also failed to note at all this significant difference in age between cases and controls, as would be customarily reported in the first table.

Nagrani et al.[33] also devote substantial discussion to the significant negative, dose-dependent association they observed with spontaneous abortion. But strangely, they hypothesize that the "it is plausible that the observed protection may reflect the protection acquired by pregnancy." However, the protective effect is known to apply only for pregnancies that last at least 32 weeks.[36] Moreover, since the number of spontaneous abortions tends to parallel the number of full-term pregnancies, and since full-term pregnancies are also protective, the observed protective effect of spontaneous abortion may result from confounding by full-term pregnancies, which their multivariate model did not account for. (They adjusted for age at FFTP instead.)

Finally, it is troubling that Nagrani et al. conclude "that the increased risk observed in our and other case-control studies is likely due to recall bias," merely on the basis of their study's being retrospective in design. This despite the clear dose-dependence of their own reported significantly positive association and the existence of so many positive South Asian studies, not one of which was cited. This is troubling because it reflects an *a priori* rejection of any real risk-increasing effect of induced abortion, a position with no scientific validity.

If the methodological violations that show up in the Nagrani study seem to have a familiar ring, the list of authors includes one Preetha Rajamaran of the US NCI, which agency of the US federal government has had a hand in covering up the ABC link for at least 23 years, by my count: your Federal tax dollars at work.

Conclusions

We have compiled a systematic review and meta-analysis of 20 ABC studies from India, Pakistan, Bangladesh and Sri Lanka which provides the strongest evidence yet of the ABC link:

1. An average increase in breast cancer risk of 150% for women with one or more abortions.

2. A significant dose effect, shown in all 5 South Asian studies that stratified data by number of abortions.
3. A highly significant meta-regression of relative risk as a function of the prevalence of abortion in the general population, providing a statistical mechanism for the ABC link to disappear, when studied in populations where abortion is the rule rather than the exception.
4. Based on the south Asian data, we project about 2 million females now alive there will ultimately die of breast cancer because of abortion.
5. The successful cover-up of the ABC link has now been extended to South Asian research, thus continuing to keep women in the dark worldwide.

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We're All Blobs of Tissue Now: How Modern Biology Has Defined Life Itself Out of Existence

Joel Brind, Ph.D.

Biology, the science of life, developed during the Enlightenment of the 17th and 18th Centuries, along with the physical sciences. Naturally, this science forms the basis of knowledge on human health and medicine. But I would argue that it was corrupt from its very beginnings, for, in its embrace of reductionism, it has developed an understanding of living systems that is perfectly backwards, as in a mirror. Not only has this limited our understanding of living systems—and the nature of human life in particular—but it has inexorably led to the increasing devaluation of human life that Western culture exhibits today.

The problem with reductionism when applied to living bodies is not the methodology of dissection and elucidation of the relationship of structure to function. After all, what understanding would we have at all of human anatomy and physiology without the pioneering—and revolutionary—work of William Harvey, a 17th Century contemporary of Galileo?

No, the problem with reductionism is the presumption that the way things come apart is merely the reverse of how they were put together. But while it seems a reasonable question to ask: "How is a living body put together?", in fact it is not a reasonable question, because the body is not put together at all. As obvious as this truth is, biology still clings to the simplistic, mechanistic assumptions of the description of animal bodies as "automata" by Descartes,[1] another contemporary of Galileo.

Thus, in the succeeding generations of scientists, building on the late 17th Century microscopic observations of Robert Hooke, did biology establish the bedrock "cell theory" by Schleiden and Schwann, in 1838. The quintessentially reductionist Cell Theory essentially states that all living things are made of cells. But is this not exactly backwards? All living things enter the world as a single cell, which grows and divides, making more and more cells as needed for all its living functions. So cells are made of

[1] Descartes R. *De Homine*, 1662.

living things, not the other way around. For example, a table or chair can be made of wood, but not a tree: Trees are not made of wood; wood is made of trees.

In fact, the 19th Century was a time of great ferment in biology; the theoretical struggle between two mutually exclusive schools of thought: mechanism and vitalism.[2] The former holds that the properties inherent in all living things can be reduced to the properties of inanimate atoms and molecules, which merely find themselves in uniquely complex arrangements in living bodies. Hence, the mechanists would argue, if all the right atoms and molecules are put together in the right measure and the right order, the properties of life "emerge," as "epiphenomena" of the physical matter. (This is somewhat different from straight reductionism, but it shares the belief that that which is more complex, such as the mind, arises only as a result of simpler physical properties). Simply put, mechanism holds that the properties of life are secondary characteristics of physical matter; in other words, that life itself has no independent existence. (That is the state of the science today: This great science of biology is devoted to the study of something which is axiomatically taken not to exist!)

Vitalism, on the other hand, holds that there is some vital force that permeates living bodies, making the atoms and molecules of living bodies different from those of inanimate matter. One of the great advocates of vitalism was the 19th Century Swedish Chemist JJ Berzelius, and among biologists, the great Louis Pasteur. In studying fermentation, Pasteur maintained that biological processes were possessed of a different sort of chemical reaction, types of reaction which could only occur in living systems. These two schools of thought: mechanism and vitalism, are diametrically opposed to each other; mechanistic theory proposing that random, rather than intelligently guided events gradually give rise to intelligent life; vitalistic theory proposing that intelligence came first—not last. Early 19th Century biologists all found themselves on one side or the other of this philosophical divide.

But vitalism crashed and burned in 1828 with the laboratory synthesis of urea by Friedrich Wöhler, at the time a former graduate student of Berzelius. Urea, you see, is a carbon-containing compound previously thought to be only makeable by living things. The demonstration that it could be synthesized in the laboratory in a non-living system was taken as proof that the atoms and molecules—the chemistry—of living systems was not fundamentally different from those of non-living systems. Even Berzelius was convinced, writing, in 1836: "There is no special force exclusively the property of living matter which may be called a vital force."

(But I would ask: Was Wöhler's synthesis of urea done posthumously? My point here is that the chemical laboratory is among many "non-biological" extensions of the human body, and whose existence is dependent upon the activity of the human mind.)

[2] Bechtel W, Richardson RC. Vitalism. In E. Craig (Ed.), *Routledge Encyclopedia of Philosophy*. London: Routledge, 1998.

That brings us to the mid-19th Century and the time of the great Charles Darwin. Darwin[3] is virtually deified by modern biologists, because his evolutionary theory purports to explain the origin of all life on earth via random physical processes, thus satisfying the reductionist paradigm.

Actually, Darwin did not take mechanism quite that far, for his theory was dependent upon the existence of life forms which could theoretically evolve over time into more complex life forms by the random process of natural selection. The great attraction of Darwinism is the simplicity of natural selection, and the fact that it is easy to prove its operation in the natural world. The great (and unsubstantiatable) leap of Darwin is that more complex life forms can evolve from simpler ones by random processes. (In fact, this aspect of the theory is easily disproven by the observation of "irreducible complexity" a term introduced by present day biochemist Mike Behe.[4]).

For the extension of mechanistic theory to the origin of life itself we must come to the 20th Century, to that wonderful time and place of 100 years ago: Moscow, 1917. That's when and where Russian biochemist, AI Oparin graduated from the Moscow State University. In 1924 Oparin wrote a short book called *The Origin of Life*.[5] The essence of Oparin's hypothesis was that before life appeared on planet earth, the primordial atmosphere and the primordial oceans contained all the necessary chemical (methane, ammonia and water) and physical (sunlight, lightning, heat of volcanic activity) ingredients to produce, spontaneously, through random interactions over time, all the necessary complex organic chemicals characteristic of living organisms, and hence, life itself. A key element in this theory, of course, was the mechanistic idea that an intelligent designer was unnecessary; a multiplicity of random events would suffice. Although Oparin's book was not translated from Russian into English until 1938, very similar ideas were also published in the mid 1920's by the very prolific and influential British geneticist J.B.S. Haldane.

Wrote Oparin in his 1924 book: "There is no fundamental difference between a living organism and lifeless matter. The complex combination of manifestations and properties so characteristic of life must have arisen in the process of the evolution of matter." Thus did Oparin firmly establish the concept of "chemical evolution"; that life itself arose, by itself, from, as it were, utter stupidity. Such an idea could more properly and informatively be called "mindless evolutionism," rather than "Darwinism." Even Haldane never went quite this far. In his 1947 book *What is Life?* he wrote: "But to suppose that one can describe life fully on these lines is to attempt to reduce it to mechanism,

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[3] Darwin C. *The Origin of Species by Means of Natural Selection*. 1872 ed. Available online at: https://en.wikisource.org/wiki/The_Origin_of_Species_(1892).

[4] Irreducible Complexity: The Challenge to the Darwinian Evolutionary Explanations of many Biochemical Structures. Intelligent Design and Evolution Awareness Center. Available online at: http://ideacenter.org/stuff/contentmgr/files/9147e04fc268407ac48a8915b73ef8e2/miscdocs/irreduciblecomplexity.pdf.

[5] Oparin AI. *The Origin of Life*. 1924. Tr. from Russian by Ann Synge. Available online at: http://www.uv.es/~orilife/textos/The%20Origin%20of%20Life.pdf.

which I believe to be impossible."[6] But so pervasive and well-entrenched was the idea of a completely mechanistic explanation for the living world, that Oparin's central idea was expressed almost verbatim over 60 years later by the American biochemist Linus Pauling, one of the most venerated scientists of the 20th century. In a 1987 interview Pauling was asked about drawing the line between mere aggregates of molecules and living organisms, and he replied: "It's quite arbitrary. The properties of living organisms are those of aggregates of molecules."[7]

There is a certain charm in the idea that life itself could have arisen—and continues to evolve—from the mere random interaction of physical matter. What could be simpler? But does it make sense not to have intelligent life follow from an intelligent designer?

Let us consider the example of a juggler. To keep our analogy simple, let us say the juggler stands between two baskets, A and B, with basket A filled with balls, all of identical size and weight. The juggler takes balls out from basket A and juggles them, 5 balls at a time, placing one ball in basket B and removing an additional ball from basket A with each cycle. Thus, the juggler finishes his act when he accomplishes the transfer of all the balls from basket A to basket B.

In our analogy, the balls represent inanimate atoms, and when in either basket they are not part of any living body. But while they are being juggled between the two baskets, they constitute part of a living body, passing through it in a highly organized manner. No one would argue that the properties of these balls are any different when they are in either basket or being juggled in between. But can anyone argue that the intelligently directed pattern of movement of the balls while being juggled is in any way inherent in the properties of the balls themselves? Of course, their particular physical properties such as size, shape and weight make them suitable for the act of juggling, but without the juggler consciously moving them in a carefully orchestrated pattern, would they ever move in such a way on their own, even in a hundred years, or a million years, or a billion years?

So how did Oparin's mechanistic theory of the origin of life become so well ensconced in present-day biological thinking? The key event was what was—and still is—widely perceived as its experimental verification by the American biochemist Stanley Miller in his 1953 Ph.D. thesis. Miller set out to put Oparin's hypothesis on the origin of life to the test. He constructed a closed system consisting of a flask containing the presumptive primordial oceans (inorganic salts in water), the presumptive primordial atmosphere (methane and ammonia), a source of heat and simulated lightning (static electrical discharges), a condenser (simulating precipitation) and a collecting flask. After only days of letting this completely inorganic system run, Miller examined the chemicals collecting in the collecting flask, and Eureka! Amino acids—so-called "organic

[6] Haldane JBS. *What is Life?* 1924. New York: Boni and Gaer. Available online at: https://www.questia.com/read/26111718/what-is-life.

[7] Interview: Linus Pauling. In Campbell N. Biology, 1st ed. 1987. Menlo Park, CA: Benjamin/Cummings.

compounds," which, like urea, were heretofore believed to be makeable only by living beings—were identified.

Miller's experiment is described in every general biology textbook published, along with descriptions of his apparatus and the conclusion that Miller had provided experimental verification of the Oparin hypothesis.

But in reality, what did Miller's experiment actually prove? Had he not merely demonstrated that some relatively complex carbon-containing compounds could be formed abiotically? In other words, Miller proved that organic compounds are not necessarily organic after all. But primed by decades of theoretical allegiance to mechanistic doctrine, the misinterpretation of Miller's results formed the capstone of fundamentalist biological doctrine that still reigns supreme over half a century later. Not long before his death in 2007, Miller expressed his own spectacular misunderstanding thus: "But now we know that there is no vital force and organic compounds are just those that contain carbon."[8] One recent biology text states matter-of-factly: "We owe our existence to an accident."[9]

The implications of this dominant point of view are profound. If "there is no vital force" and if living beings are no more than "aggregates of molecules," are we not really saying that in reality, there is no such thing as life itself? Does this make sense? Not to Professor Albert Einstein, whose views were most succinctly expressed in a letter he wrote in 1936: "(E)very one who is seriously engaged in the pursuit of science becomes convinced that the laws of nature manifest the existence of a spirit vastly superior to that of men, and one in the face of which we with our modest powers must feel humble."[10]

[8] Interview: Stanley Miller. In Campbell N. Biology, 2nd ed. 1990. Redwood City, CA: Benjamin/Cummings.

[9] Guttman BS. *Biology*. 2001. New York: McGraw Hill.

[10] Jammer M. *Einstein and Religio*n. 1999. Princeton: Princeton University Press.

Overruling Roe v. Wade: The Implications for the Law

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The election of Donald Trump as president on November 8, 2016, and the possibility that he may have the opportunity to replace several justices on the Supreme Court, have fueled speculation that the Court, with new appointments, may ultimately overrule *Roe v. Wade*,[1] as modified by *Planned Parenthood v. Casey*,[2] and return the issue of abortion to the States. This paper explores the likelihood of an overruling decision and, more importantly, what the implications of such a decision would have for the legality of abortion.

Evaluation of the Court and Prospects for Change

Presently, there is only one justice on the Supreme Court who is on record as calling for *Roe* to be overruled—Justice Clarence Thomas. Based upon his published judicial opinions and general jurisprudential philosophy, Justice Samuel Alito would likely be a second vote to overrule *Roe*. Although it would be premature to "handicap" how Justice Neil Gorsuch would vote, his background on the Tenth Circuit, his publications both on and off the bench and his opinions as a Supreme Court justice strongly suggest that he would be a third vote to overrule *Roe*. Although a number of persons are of the opinion that Chief Justice John Roberts would vote to overrule *Roe*, that is doubtful for at least two reasons. First, the Chief Justice appears to have an exaggerated respect for the principle of *stare decisis*, that is, the rule of adhering to prior precedent. This has been manifested in a number of opinions he has written where he takes a "minimalist" approach to limiting or modifying prior precedents with which he disagrees. Given that *Roe v. Wade* has been the law of the land for more than forty years and has been reaffirmed three times since then,[3] it is questionable whether Chief Justice Roberts would be willing to cast the deciding vote to overturn a precedent of *Roe*'s pedigree. Second, based upon his opinion upholding the constitutionality of the Affordable Care Act,[4] on a theory that is difficult to accept at face value (to wit, that what was clearly

[1] 410 U.S. 113 (1973).

[2] 505 U.S. 833 (1992).

[3] *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983), *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1988), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

[4] *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

drafted and intended as a *penalty* for not obtaining health insurance should be regarded instead as a *tax*), the Chief Justice appears to be influenced by political considerations. Perhaps with the Supreme Court's decision in *Bush v. Gore*[5] in mind, he did not want to cast the deciding vote against the principal domestic policy achievement of President Obama's first term in a case that would have come out on a vote of five-to-four, with five Republican appointees on one side of the case (the Chief Justice, along with Justices Kennedy, Scalia, Thomas and Alito) and four Democratic appointees on the other side (Justices Ginsburg, Breyer, Sotomayor and Kagan), and would have made the Court an issue in the presidential election of 2012. So, although Chief Justice Roberts might be willing to be the sixth vote to overrule *Roe v. Wade*, it is questionable whether he would be willing to cast the decisive fifth vote to do so. Given his Joint Opinion with Justices O'Connor and Souter, joined in this respect by Justices Blackmun and Stevens, reaffirming *Roe v. Wade* in *Planned Parenthood v. Casey*, Justice Anthony Kennedy cannot plausibly be regarded as a vote to overrule *Roe*. Nothing in his dissenting opinion in the first partial-birth abortion case, *Stenberg v. Carhart*,[6] or his majority opinion in the second partial-birth abortion case, *Gonzales v. Carhart*,[7] indicates otherwise. Indeed, in the former case, Justice Kennedy stated "Nebraska must obey the legal regime which has declared the right of the woman to have an abortion before viability."[8] Any doubts about Justice Kennedy's continued adherence to *Roe* should have been dispelled by his joining Justice Breyer's majority opinion in *Whole Woman's Health v. Hellerstedt*,[9] last year, striking down two modest health regulations the State of Texas had imposed on abortion providers, that they have admitting privileges at a local hospital and that their facilities comply with the standards generally applicable to outpatient surgical facilities.

To summarize, there are probably three justices on the current Court who would be willing to vote to overrule *Roe v. Wade*—Justice Thomas, Justice Alito and Justice Gorsuch. So, two more votes are needed. As is well known, there was rampant speculation that Justice Kennedy would retire at the end of the last Supreme Court Term. Of course, he did not retire, but there is still some reason to believe that he may retire after the next Term ends, in June 2018. Keep in mind that in replacing Justice Scalia, who died early in 2016, President Trump appointed as his successor Neil Gorsuch, who had once been a law clerk for Justice Kennedy and who was said to be one of his favorite law clerks. Justice Gorsuch's appointment likely raised Justice Kennedy's comfort level in the type of person President Trump would nominate to replace him. Moreover, although Justice Kennedy has written some very disturbing opinions, including (along with Justices O'Connor and Souter) *Planned Parenthood v. Casey* and the opinion requiring the States to license and recognize same-sex marriages, *Obergefell v. Hodges*,[10] he would probably

[5] 531 US. 98 (2000).
[6] 530 U.S. 914 (2000).
[7] 550 U.S. 124 (2007).
[8] *Stenberg*, 530 U.S. at 963-74 (Kennedy, J., dissenting).
[9] 579 U.S. _____ (2016).
[10] 576 U.S._____ (2015).

want to be replaced by a justice nominated by a Republican president. Justice Kennedy's retirement next summer would give President Trump a second appointment to the Court (after Justice Gorsuch). Justice Ginsberg is 84 years old and is reportedly not in the best of health. Although she is likely to stay on the Court as long as possible while there is a Republican in the White House, it is certainly possible that President Trump would be able to appoint her replacement.

The Impact of an Overruling Decision

The immediate impact of a Supreme Court decision overruling *Roe v. Wade* has been subject of much comment over the years, by both supporters of *Roe* and opponents of *Roe*. The former fear (or *say* that they fear) that an overruling decision would promptly result in abortion becoming illegal throughout much or most of the country. The latter hope that they are right. Both, in fact, are wrong.

Pre-Roe Statutes

Pre-*Roe* abortion statutes fell into five categories. Thirty States prohibited abortion except to save the life of the pregnant woman.[11] Thirteen States adopted one version or another of the Model Penal Code provision on abortion (§ 230.3) drafted by the American Law Institute,[12] allowing abortion to preserve the woman's life, her physical or mental health, to end a pregnancy resulting from rape or incest or to end a pregnancy where the child would likely be born with a physical or mental defect (the precise wording of the permissible reasons for performing abortions under these statutes differed from

[11] *Arizona*: Ariz. Rev. Stat. Ann. §§ 13-211, 13-212 (1956); *Connecticut*: Conn. Gen. Stat. Ann. §§ 53-29, 53-30 (West 1960); *Idaho*: Idaho Code §§ 18-601, 18-602 (Supp. 1972); *Illinois*: Ill. Rev. Stat. ch. 38, ¶ 23-1 (1971); *Indiana*: Ind. Code. Ann. §§ 35-1-58-1, 35-1-58-2 (Burns 1971); *Iowa*: Iowa Code § 701.1 (1950); *Kentucky*: Ky. Rev. Stat. §§ 436.020,436.040 (Michie 1962); *Louisiana*: La. Rev. Stat. Ann. § 14:87 (1964), construed *in pari materia* with La. Rev. Stat. Ann. § 32:1285(6), *see Rosen v. Louisiana State Board of Medical Examiners*, 318 F. Supp. 1217, 1225 (E.D. La. 1970), *vacated and remanded*, 412 U.S. 902 (1973); *Maine*: Me. Rev Stat. Ann. tit. 17, § 51 (West 1964); *Michigan*: Mich. Comp. Laws Ann. §§ 750.14, 750.323 (West 1968); *Minnesota*: Minn. Stat. Ann. §§ 617.18, 617.19 (West 1971); *Missouri*: Mo. Ann. Stat. § 599.100 (Vernon 1969); *Montana*: Mont. Code Ann. §§ 94-401, 94-402 (1969); *Nebraska*: Neb. Rev. Stat. §§ 28-404, 28-405 (1964); *Nevada*: Nev. Rev. Stat. §§ 200.220, 201.120 (1967); *New Hampshire*: N.H. Rev. Stat. Ann. § 585.12 *et seq*. (1955); *New Jersey*: N.J. Stat. Ann. § 2A:87-1 (West 1969) (prohibiting performance of an abortion upon a pregnant woman "maliciously or without lawful justification," which language was interpreted by the New Jersey Supreme Court to allow abortions necessary to save the life of the woman, *State v. Moretti*, 244 A.2d 499, 504 (N.J. 1968)); *North Dakota*: N.D. Cent. Code § 12-25-01 (1970); *Ohio*: Ohio Rev. Code Ann. § 2901.16 (Baldwin 1953); *Oklahoma*: Okla. Stat. Ann. tit. 21, §§ 861, 862 (West 1971); *Pennsylvania*: Pa. Stat. Ann. tit. 18, §§ 4718, 4719 (West 1963) (prohibiting "unlawful" abortions without defining what abortions were "unlawful"); *Rhode Island*: R.I. Gen Laws § 11-3-1 (1956); *South Dakota*: S.D. Complied Laws §§ 22-17-1, 22-17-2 (1967); *Tennessee*: Tenn. Code Ann. §§ 39-301, 39-302 (1956); *Texas*: Texas Penal Code Ann. articles 1191, 1192, 1193, 1194, 1196 (West 1961), *transferred to* Tex. Rev. Civ. Stat. Ann. articles 4512.1, 4512.2, 4512.3, 4512.4, 4512.6 (West 1976); *Utah*: Utah Code Ann. §§ 76-2-1, 76-2-2 (1953); *Vermont*: Vt. Stat. Ann. tit. 13, § 101 (1972); *West Virginia*: W.Va. Code § 61-2-8 (1966); *Wisconsin*: Wis. Stat. Ann. § 940.04 (1971); *Wyoming*: Wyo. Stat. § 6-77 (1957).

[12] The complete text of § 230.3 of the Model Penal Code is set out in Appendix B to the Supreme Court's decision in *Doe v. Bolton*, 410 U.S. 410 U.S. 179, 205-07 (1973).

State to State).[13] Two States—by statute or court interpretation—allowed abortion either for undefined reasons of health or for both physical and mental health reasons.[14] One State allowed abortion to save the woman's life or to end a pregnancy resulting from rape.[15] Finally, four States allowed abortion for any reason ("on demand") at least until late in pregnancy.[16]

Mental Health Exceptions

Some comment is appropriate about the mental health exceptions in the pre-*Roe* statutes based upon the Model Penal Code. In 1967 the California Legislature enacted the Therapeutic Abortion Act.[17] Under the Act, an abortion could be performed (up to the twentieth week of pregnancy) to prevent "grave impairment" to the pregnant woman's physical or mental health and to end pregnancies resulting from rape or incest.[18] Under the Act, an abortion for reasons permitted thereunder had to be approved by a hospital committee consisting of at least two physicians (or three, if the abortion was to be performed after the thirteenth week of pregnancy) and their approval had to be unanimous (if the committee consisted of no more than three physicians).[19] An abortion could not be performed for mental health reasons unless it appeared that the pregnant woman suffered from a "mental illness to the extent that [she] is dangerous to herself or to the person or property of others or is in need of supervision or restraint."[20] This definition,

[13] *Arkansas*: Ark. Stat. Ann. § 41-303 *et seq*. (Supp. 1969); *California*: Cal. Health & Safety Code § 25950 *et seq*. (West Supp. 1971) (law did not include exception for fetal anomaly); *Colorado*: Colo. Rev. Stat. § 40-6-101 *et seq*. (Perm. Supp. 1971); *Delaware*: 57 Del. Laws, chapters 145, 235, 344, 58 Del. Laws, ch. 497, at 1623, *codified at* Del. Code Ann. tit. 11, §§ 222(21), 651-654 (1975), *ibid*. tit. 24, §§ 1766(b), 1790-1793 (1975); *Florida*: 1972 Fla. Laws 608, ch. 72-196; *Georgia*: Ga. Code Ann. § 26-1201 *et seq*. (1972): *Kansas*: Kan. Stat. Ann. § 21-3407 (Vernon 1971); *Maryland*: Md. Code Ann. art. 43, § 137 (1971) (law did not contain exception for incest); *New Mexico*: N.M. Stat. Ann. § 40A-5-1 *et seq*. (Michie 1972) (subsequently renumbered as § 30-5-1 *et seq*.); *North Carolina*: N.C. Gen. Stat. § 14-44 *et seq*. (1969); *Oregon*: Or. Rev. Stat. § 435.405 *et seq*. (1969); *South Carolina*: S.C. Code Ann. § 16-82 *et seq*. (1971); *Virginia*: Va. Code Ann. § 18.1-62 *et seq*. (Michie Supp. 1971).

[14] *Alabama*: Ala. Code tit. 14, § 9 (1958); *Massachusetts*: Mass. Gen Laws Ann. ch. 272, § 19 (West 1968) (prohibiting "unlawful" abortions without defining what abortions were "unlawful"). In a series of pre-*Roe* decisions, the Massachusetts statute was interpreted to allow an abortion if, in the good faith judgment of the physician, the procedure was necessary to preserve the pregnant woman's life or her physical or mental health. *See Kudish v. Board of Registration in Medicine*, 248 N.E.2d 264, 265–66 (Mass. 1969); *Commonwealth v. Brunelle*, 171 N.E.2d 850, 851–52 (Mass. 1961); *Commonwealth v. Wheeler*, 53 N.E.2d 4, 5 (1944).

[15] *Mississippi*: Miss. Code Ann. § 2223 (Supp. 1970) (subsequently renumbered as § 97-3-3).

[16] *Alaska*: Alaska Stat. § 11.15.060 (1970) (before viability); *Hawaii*: Haw Rev. Stat. § 453-16 (Supp. 1971) (before viability and, because of the structure of the statute, at any time after viability, as well); *New York*: N.Y. Penal Law § 125.00 *et seq*. (McKinney Supp. 1971) (twenty-four weeks); *Washington*: Wash. Rev. Code § 9.02.060 *et seq*. (West Supp. 1971) (before "quickening" and within four lunar months).

[17] Cal. Health & Safety Code § 25950 *et seq*. (West Supp. 1971).

[18] *Ibid*. § 25951. Under a separate provision of California law, an abortion could be performed at any stage of pregnancy to preserve the pregnant woman's life. CAL. PENAL CODE §§ 274, 275 (West. Supp. 1971).

[19] Cal. Health & Safety Code § 25951 (West Supp. 1971).

[20] *Ibid*. § 25954.

the *only* attempt to define the scope of a mental health exception in an abortion law in the United States prior to the Supreme Court's decision in *Roe*, was essentially the same standard that is used to determine whether a person may be involuntarily committed because he is a danger to himself or to others, a very strict standard that, one would think, could not be easily met.

In 1972, a four-to-three majority of the California Supreme Court declared major provisions of the Therapeutic Abortion Act unconstitutional because, in the view of the majority of the court, several of its key provisions were too vague to understand.[21] What is of particular interest in *Barksdale* is the court's discussion of the numbers and reasons for abortions performed in California in 1970. In that year, more than 65,000 (sixty-five thousand) abortions were approved by hospital committees and almost 63,000 (sixty-three thousand) abortions were performed. More than 98% of the approvals (63,872) and more than 98% of the abortions performed (61,572) were "for reasons of mental health."[22] These astonishing figures perplexed the California Supreme Court:

> Serious doubt must exist that such a considerable number of pregnant women could have been committed to a mental institution. Either pregnancy carries risks to mental health beyond those ever imagined, or legal writers and members of therapeutic abortion committees, two groups we must assume to be of at least common intelligence, have been forced to guess at the meaning of this provision and have reached radically different interpretations.[23]

There is a third, and more plausible, explanation—that the physicians serving on the hospital committees routinely approved abortions for reasons of mental health because they were determined to approve the abortions, knew that their approvals were not subject to review by any court or agency and understood that no other reason could plausibly be invoked to "justify" the abortion.

The California Supreme Court's conclusion that the standard for approving an abortion for mental health reasons was impermissibly vague cannot be squared with the fact that the very same standard—essentially the standard used for civil commitment—is one that has been used throughout the United States, including California, for many decades, all without any suggestion or indication that the standard is incomprehensible. The experience with the California Therapeutic Abortion Act of 1967 demonstrates that a mental health exception, even a narrowly drafted one that employs a well-established standard (e.g., the standard for civil commitment) could not be limited to genuine mental health reasons. Accordingly, whenever *Roe* is overruled, States that intend to restrict abortions to serious health reasons should not consider including a mental health exception in their legislation, otherwise the exception would likely swallow the rule.

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[21] *People v. Barksdale*, 503 P.2d 257 (Cal. 1972).

[22] *Ibid*. at 265.

[23] *Ibid*.

Undefined Health Exceptions

In 1901, Congress enacted a code of law for the District of Columbia which included a statute that allowed abortion if the procedure was necessary "for the preservation of the mother's life or health."[24] In *United States v. Vuitch*,[25] the Supreme Court considered a vagueness challenge to the statute; what does "health" mean? The Court rejected the challenge, stating that the undefined word "health" "includes psychological as well as physical well-being," and concluding that "whether a particular operation is necessary for a patient's physical or mental health is a judgment that physicians are obviously called upon to make routinely whenever surgery is considered."[26]

In *Doe v. Bolton*,[27] the companion case to *Roe v. Wade*, the Supreme Court rejected a vagueness challenge to a Georgia abortion statute which, as interpreted by the district court, allowed a physician to perform an abortion whenever he determined it was "necessary." Relying upon its decision in *Vuitch*, the Court said that "the medical judgment" as to whether an abortion is "necessary" "may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age–relevant to the well-being of the patient. All these factors may relate to health."[28] The Court's decisions in *Vuitch* and *Bolton* suggest that, like a mental health exception, an undefined health exception in a statute prohibiting abortion could not be contained.

The Impact of Roe *and the Repeal of State Abortion Statutes*

Roe v. Wade effectively overturned the abortion laws of all fifty States and made abortion legal for any reason before viability and, arguably, for virtually any reason after viability, although the Court has not yet decided how broad or narrow is the scope of the authority of the States to prohibit post-viability abortions. Because *Roe* made abortion legal throughout the country, it is natural to believe that a decision overruling *Roe* would make abortion illegal throughout the country. But, of course, that is not the case. The Supreme Court does not decide what conduct is illegal, only what conduct can be made illegal.

Three-fourths of the States (thirty-seven States) have expressly repealed their pre-*Roe* statutes, which would not be revived or reinstated by a decision overruling *Roe v.*

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[24] 31 Stat. 1322, ch. 854, § 809, *codified as* D.C. CODE ANN. § 22-201 (1967) (renumbered as § 22-101 in 1988), repealed by Act No. 15-255 (Nov. 25, 2003), D.C. Law 15-154.

[25] 402 U.S. 62 (1971).

[26] *Ibid*. at 72.

[27] 410 U.S. 179 (1973).

[28] *Ibid*. at 192.

Wade.[29] Four of those States, however, have enacted post-*Roe* statutes that would make most abortions illegal again upon the overruling of *Roe*.[30]

One-fourth of the States have not repealed their pre-*Roe* statutes (thirteen States).[31] The statutes in six of these States would not affect the legality of most abortions. The

[29] *Alaska*: 1997 Alaska Sess. Laws ch. 14, § 6; *California*: 2000 Cal. Stat. ch. 692 § 2 (repealing provisions in Penal Code), 2002 Cal. Stat. ch. 385, §§ 2-7 (repealing provisions in Health & Safety Code); *Colorado*: 2013 Laws, ch. 372, § 3, p. 2192; *Connecticut*: 1990 Conn. Acts 90-113, § 4 (Reg. Sess.); *Delaware*: Senate Substitute No. 1 for Senate Bill No. 5, 149th Delaware General Assembly, 81 Del. Laws ch.35; *Florida*: 1979 Fla. Laws 1618, ch. 79-302, § 5; *Georgia*: Ga. Laws No. 328, § 1 (1973), Vol. 1 Ga. Acts & Resolutions 635, 636-37 (1973); *Idaho*: 1973 Idaho Sess. Laws 443, ch. 197, § 2; *Illinois*: Ill. Public Act 78-225, § 10 (1973); *Indiana*: 1977 Ind. Acts 1513, 1524, Pub. L. No. 335, § 21; *Iowa*: 1976 Iowa Acts 549, 774, ch. 1245, § 526; *Kansas*: 1992 Kan. Sess. Laws 723, 729, ch. 183, § 9; *Kentucky*: 1974 Ky. Acts 484, 487, ch. 255, § 19; 1974 Ky. Acts 831, 889, ch. 406, § 336; *Louisiana*: 1991 La. Acts No. 26, § 2, 2006 La. Acts No. 467, § 2); *Maine*: 1979 Me. Laws 513, ch. 405, § 1 (1st Sess.); *Maryland*: 1991 Md. Laws 1, ch. 1, § 1; *Minnesota*: 1974 Minn. Laws 265, ch. 177, § 7; *Missouri*: 1977 Mo. Laws 658, 662-63; *Montana*: 1977 Mont. Laws 1130, 1171-72, ch. 359, § 77; *Nebraska*: 1973 Neb. Laws 801, 806, L.B. 286, § 24; *Nevada*: 1973 Nev. Stat. 1637, 1639-40, ch. 766, §§ 7, 8; *New Hampshire*: 1997 N.H. Laws 81, ch. 99, § 1; *New Jersey*: 1978 N.J. Laws 482, 687-88, ch. 95, § 2C:98-2; *North Carolina*: 1973 N.C. Sess. Laws 1057-58, ch. 711, §§ 1, 2; *North Dakota*: 1973 N.D. Laws 215, 300, ch. 116, § 41; *Ohio*: 135 Ohio Laws 988 (1974); *Oregon*: 1983 Or. Laws 868, ch. 470, § 1; *Pennsylvania*: 1974 Pa. Laws 639, Acts No. 209, § 10; *Rhode Island*: 1973 R.I. Pub. Laws 67, 68, ch. 15, § 1; *South Carolina*: 1974 S.C. Acts 2837, 2841, Act No. 1215, § 8; *South Dakota*: 1973 S.D. Laws 206, 209 ch. 146, § 15; 1976 S.D. Laws 227, 257, ch. 158, § 17-1; 1977 S.D. Laws 258, 282, ch. 189, § 126; *Tennessee*: 1973 Tenn. Pub. Acts 901 *et seq*., ch. 235, §§ 1, 3; *Utah*: 1973 Utah Laws 584, 684, ch. 196 (sub.) ch. 10, pt. 14, § 76-10-1401; *Vermont*: 2013 Vt. Acts, No. 98, § 1 (Adj. Sess.); *Virginia*: 1975 Va. Acts 18, ch. 14, § 1, ch. 15, § 1; *Washington*: 1992 Wash. Laws, ch. 1, § 9, Initiative Measure No. 120, approved Nov. 5, 1991; *Wyoming*: 1977 Wyo. Sess. Laws 11, 14, ch. 11, § 2.

[30] *Louisiana*: La. Rev. Stat. Ann. §§ 14:87 (2012), 40:1061 (Supp. 2016) (prohibiting abortion except to preserve the life of the pregnant woman or to prevent permanent impairment of a life-sustaining organ); *North Dakota*: N.D. Cent. Code § 12.1-31-12 (2009) (prohibiting abortion except to prevent the death of the pregnant woman or where the pregnancy resulted from "gross sexual imposition, sexual imposition, sexual abuse of a ward, or incest); *Rhode Island*: R.I. Gen. Laws § 11-3-1 (2002) (life-of-the-mother only); *South Dakota*: S.D. Codified Laws § 22-17-5-1 (2006). The Louisiana, North Dakota and South Dakota statutes are "trigger" laws that would take effect only upon the overruling of *Roe v. Wade*; the Rhode Island statute, enacted in response to *Roe* and not currently in effect, would be enforceable upon the overruling of *Roe*.

[31] *Alabama*: Ala. Code § 13A-13-7 (LexisNexis 2005); *Arizona*: Ariz. Ann. Rev. Stat. §§ 13-3603, 13-2604 (LexisNexis 2015); *Arkansas*: as previously noted, the pre-*Roe* abortion statute was based upon § 230.3 of the Model Penal Code but, as a result of a post-*Roe* codification of Arkansas law in 1987, all of the provisions of the pre-*Roe* statute (including the exceptions allowing abortion for various reasons) were repealed, other than the prohibition itself and a provision protecting the rights of conscience of physicians opposed to abortion, *see* Ark. Code Ann. §§ 5-61-102 (2005) (prohibition), 20-16-601 (rights of conscience); (2014); *Hawaii*: Haw. Rev. Stat. § 453-16 (LexisNexis 2015); *Massachusetts*: Mass. Gen. Laws Ann. ch. 272, § 19 (West 2014); *Michigan*: Mich. Comp. Laws Ann. §§ 750.14, 750.323 (West 2004); *Mississippi*: Miss. Code Ann. § 97-3-3 (West 2011) (Mississippi has also enacted a "trigger" law, with the same prohibition, that would take effect upon the overruling of *Roe v. Wade*, Miss. Code Ann. § 41-41-45 (West Supp. 2014), but which would not be enforceable on state constitutional grounds, *see* n. 42, *infra*, and accompanying text); *New Mexico*: N.M. Stat. Ann. § 30-5-1 *et seq*. (LexisNexis 2004); *New York*: N.Y. Penal Law § 125.00 *et seq*. (McKinney 2009); *Oklahoma*: Okla. Stat. Ann. tit. 21, §§ 861, 862 (West 2002);

Hawaii and New York statutes allow abortion-on-demand throughout pregnancy (Hawaii) or through twenty-four weeks (New York); the Alabama and Massachusetts statutes allow abortions either for undefined reasons of health (Alabama) or for both physical and mental health reasons (Massachusetts); the New Mexico statute allows abortion for a broad range of reasons, including mental health; and both the New Mexico and Mississippi statutes would be unenforceable on state constitutional grounds.[32]

The unrepealed pre-*Roe* statutes in seven States would prohibit all abortions (Arkansas) or all abortions except those necessary to save the life of the mother (Arizona, Michigan, Oklahoma, Texas, West Virginia and Wisconsin). In sum, no more than eleven States would have enforceable laws on the books prohibiting most or all abortions if *Roe* were overruled—the seven States just named, along with the four discussed earlier—Louisiana, North Dakota, Rhode Island and South Dakota. Those eleven States account for only 20% of the population of the United States. In the other thirty-nine States, where 80% of the population lives, abortion would be legal for most or all reasons throughout pregnancy. Even in those eleven States, however, there may be some doubt as to whether all those statutes would be enforceable.

Implied Repeal

There is a doctrine in American law called repeal by implication. Under this doctrine, a later enacted statute may repeal by implication an earlier enacted statute if the two statutes are determined to be in irreconcilable conflict. Repeal by implication is disfavored in the law and courts generally will try to harmonize statutes that, at least on the surface, appear to conflict.

In the area of abortion, a repeal-by-implication argument would basically claim that the enactment of *post-Roe* statutes *regulating* abortion cannot be reconciled with *pre-Roe* statutes *prohibiting* abortion because the State cannot regulate that which it prohibits. As a consequence, even in the absence of express repeal, according to this argument, enactment of abortion regulations after *Roe* must have repealed by implication abortion prohibitions enacted before *Roe*. Although a federal court of appeals has accepted this argument and has held that the pre-*Roe* Texas statutes prohibiting abortion were repealed by implication with post-*Roe* statutes regulating abortion,[33] the opinion is not binding upon a state court, presenting, as it does, purely a matter of state law,[34] and, in any event, is unpersuasive on its own terms. As an initial matter, the court did not

Texas: Tex. Rev. Civ. Stat. Ann. articles 4512.1, 4512.2, 4512.3, 4512.4, 4512.6 (West 1976) (although the Texas statutes struck down in *Roe* have not been reprinted in the current volumes of the Texas Penal Code or the Texas Revised Civil Statutes, they have not been repealed by the Texas Legislature); *West Virginia*: W.Va. Code § 61-2-8 (2014); *Wisconsin*: Wis. Stat. Ann. § 940.04 (West 2005).

[32] *See New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841 (N.M. 1998) (striking down abortion funding restrictions on the basis of the state equal rights amendment); *Moe v. Secretary of Administration & Finance*, 417 N.E.2d 387 (Mass. 1981) (same on the basis of a state constitutional implied right of privacy).

[33] *McCorvey v. Hill*, 385 F.3d 846, 849 (5th Cir. 2004).

[34] *Westchester Fire Insurance v. Admiral Insurance*, 152 S.W.3d 172, 183 (Tex. App.–Fr. Worth 2004, *no writ*) ("in matters of state law, state courts are not bound by decisions of federal courts of appeals").

need to address the issue of repeal-by-implication because the underlying issue was whether the pseudonymous plaintiff in *Roe v. Wade* (Norma McCorvey) had standing to seek to reopen the district court's judgment in that case. Because Ms. McCorvey was not pregnant at the time she sought to relitigate *Roe*, she lacked standing, in either an individual or representative capacity, to attack the underlying judgment. Apart from that, the repeal-by-implication analysis is deeply flawed. In a remarkable error of analysis, the court of appeals relied in part upon a post-*Roe administrative regulation* restricting public funding of abortion in support of its repeal-by-implication holding.[35] Of course, an administrative regulation cannot repeal by implication a duly enacted statute. Moreover, as one commentator has noted, "a claim that a subsequent *regulation* of abortion has impliedly repealed a prior *prohibition* should fail, given the need to regulate those abortions which are lawful under the prohibition, combined with the general presumption against implied repeal."[36] Finally, the court of appeals simply ignored the fact that Texas enacted statutes regulating the practice of abortion only because its statutes prohibiting abortion were not, in light of *Roe*, constitutionally enforceable. An intent to repeal the pre-*Roe* prohibitions cannot be imputed to a legislature that has merely sought to regulate what it cannot, for the time being, prohibit. As Professor Smolin has explained, "the judicial constraint upon enforcement of the prohibition is in itself a sufficient explanation of the claimed conflict [between the pre-*Roe* prohibition and the post-*Roe* regulations]."[37] Accordingly, "[t]he passage of regulatory provisions after *Roe* is evidence of a desire to fill a gap created by the judiciary, rather than evidence of a desire to repeal abortion prohibitions."[38] In sum, "[t]he doctrine of implied repeal should not be used as a backdoor effort to exercise a judicial power of repeal of statutes that, under our system of separation of powers, cannot and does not exist."[39]

In contrast to the Fifth Circuit's superficial and unconvincing repeal-by-implication analysis in *McCorvey v. Hill*, both the Michigan Court of Appeals and the Wisconsin Supreme Court have rejected repeal-by-implication arguments, holding that their pre-*Roe* statutes prohibiting abortion except to the save the life of the pregnant woman have

[35] *McCorvey*, 385 F.3d at 849, citing, *inter alia*, 25 Tex. Admin. Code § 29.1121 (2002).

[36] David M. Smolin, *The Status of Existing Abortion Prohibitions in a Legal World without Roe: Applying the Doctrine of Implied Repeal to Abortion*, 11 St. Louis U. Pub. L. Rev. 385, 399-400 (1992) (emphasis in original). The two statutes on which the Fifth Circuit relied in finding repeal by implication—the parental notice statute and the statute regulating abortion clinics—do not create an irreconcilable conflict with the pre-*Roe* statutes prohibiting abortion. Given the legality of abortions required to save the life of the mother, both statues would have some (albeit limited) room to operate. The statute regulating abortion clinics would ensure that any abortion undertaken to save the life of the mother would be performed under conditions that would be as safe as possible for her. The parental notice statue would apply in those cases in which life-threatening circumstances did not pose an immediate risk of death to a minor.

[37] *Ibid*. at 401.

[38] *Ibid*.

[39] *Ibid*. at 402. As an example of a proper application of the doctrine of repeal-by-implication see *Smith v. Bentley*, 493 F. Supp. 916 (E.D. Ark. 1980) (holding that enactment of pre-*Roe* statute based upon the Model Penal Code allowing abortions under a broad range of reasons implicitly repealed a nineteenth century statute prohibiting abortions except to save the life of the mother).

not been repealed by implication with the enactment of post-*Roe* statutes regulating abortion.[40] No state court has adopted or followed the flawed reasoning of the Fifth Circuit in *McCorvey v. Hill*.[41]

State Constitutional Issues

In addition to the repeal-by-implication argument, abortion advocates would likely argue that state abortion prohibitions violate one or more provisions of a State's constitution. State constitutions may be interpreted in ways that are independent of the federal constitution and provide broader rights. Ten state supreme courts have already recognized a state right to abortion that is separate from, and independent of, the federal right to abortion,[42] although the decision in one of those States (Tennessee) has been overturned by state constitutional amendment which the author helped to draft. Only one of those decisions is in a State where there is either a pre- or post-*Roe* statute on the books prohibiting most or all abortions (Mississippi). An eleventh State—Vermont—has a pre-*Roe* state supreme court decision that appears to recognize a right to abortion,[43] but it is unclear whether the decision rests on state or federal law (or both). A state supreme court in a twelfth State—New Mexico—has struck down restrictions on public funding of abortion on the basis of the state Equal Rights Amendment,[44] but without deciding whether there is a state right to abortion. The decision, however, would likely require invalidation of any meaningful abortion restriction the state legislature might enact. As of this writing, there are state constitutional challenges pending to abortion statutes in Iowa, Kansas and Oklahoma. There is no doubt that state constitutional challenges would be brought against state abortion statutes upon the overruling of *Roe v. Wade*. The success of at least some of those challenges would further reduce the number of States that would have abortion statutes on the books that would be enforceable.

Express Repeal

Needless to say, at the same time abortion advocates would be in state court presenting implied repeal or state constitutional arguments, they would also be in state legislatures seeking to repeal existing abortion statutes. Regardless of the success of

[40] *People v. Higuera*, 625 N.W.2d 444, 448-49 (Mich. Ct. App. 2001); *State v. Black*, 526 N.W.2d 132, 135, n. 2 (Wis. 1994).

[41] The issue of repeal-by-implication has not been addressed by the reviewing courts in any other State.

[42] *State v. Planned Parenthood of Alaska*, 35 P.3d 30 (Alaska 2001); *State of Alaska, Dep't of Health & Human Services v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904 (Alaska 2001); *Valley Hospital Ass'n v. Mat-Su Coalition for Choice*, 948 P.2d 963 (Alaska 1997); *Committee to Defend Reproductive Rights v. Myers*, 625 P.2d 779 (Cal. 1981); *In re T.W.*, 551 So.2d 1186 (Fla. 1989); *Moe v. Secretary of Administration & Finance*, 417 N.E.2d 387 (Mass. 1981); *Women of the State of Minnesota v. Gomez*, 542 N.W.2d 17 (Minn. 1995); *Pro-Choice Mississippi v. Fordice*, 716 So.2d 645 (Miss. 1998); *Armstrong v. State*, 989 P.2d 364 (Mont. 1999); *Right to Choose v. Byrne*, 450 A.2d 925 (N.J. 1982); *Hope v. Perales*, 634 N.E.2d 183 (N.Y. 1994) (by implication); *Planned Parenthood of Middle Tennessee v. Sundquist*, 38 S.W.3d 1 (Tenn. 2000) (overturned by state constitutional amendment).

[43] *Beacham v. Leahy*, 287 A.2d 836 (Vt. 1972).

[44] *New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841 (N.M. 1998).

failure of any of these strategies, however, no more than eleven States—the ones mentioned above—would have enforceable statutes on the books that would prohibit most abortions upon the overruling of *Roe v. Wade*.

Alternatives to Prohibitions

In thinking about a legal environment in which the States could exercise their traditional authority over the practice of abortion, both supporters and opponents of legalized abortion tend to think exclusively in terms of States *prohibiting* abortion, as opposed to *regulating* abortion. There is, of course, another option that a number of States might want to consider, and that is to enact regulations that might not pass muster under current constitutional doctrine, but would be permissible options in a post-*Roe* setting. Such options could include requiring parental consent or notice without a judicial bypass mechanism; requiring spousal consent or notice; mandating longer waiting periods (as is the case in some European countries); banning specific abortion procedures (*e.g.*, dismemberment abortions); or mandating counseling by third party entities that have no financial or other association with abortion clinics (as is the case in Germany). Many other regulatory options could be considered, especially in those States where there would be no consensus in support of enacting a prohibition.

Conclusion

It is hard to say when *Roe v. Wade* will be overruled, but it easy to say that the overruling of *Roe* will not have the immediate dramatic consequences that advocates of legal abortion claim that it would. In the absence of new legislation prohibiting abortion, for which there would have to be a contemporary political consensus supporting such legislation, abortion would remain legal throughout most of the country throughout most of pregnancy. Even in States that have prohibitions on the books, such prohibitions would be challenged on the basis that they have been repealed by implication with the enactment of statutes regulating abortion, that their enforcement is precluded on state constitutional grounds or, failing either of those gambits, that they should be expressly repealed. The overruling of *Roe* is the indispensable first step toward reestablishing legal protection for unborn children, but it is only the first step. Much work will remain to be done—in state and federal courts, in state legislatures and in the hearts and minds of the American people.

Reproductive Loss: Giving Permission to Grieve

Michaelene Fredenburg, President & CEO, Life Perspectives

In spite of studies revealing that the reaction of medical professionals to a pregnancy loss sticks with the parents "forever" and influences how they cope with the loss, adequate training is rarely provided (Lang, et. al.). This workshop explores the role of medical professionals in acknowledging reproductive loss and setting the stage for their patients to grieve and heal.

Objectives:

- Describe the prevalence of reproductive loss.
- Recognize the role of medical professionals in the grieving process.
- Explore practical responses in the ER and/or private practice setting.

Grief Denied

As a teenager I assumed that abortion produced few negative emotional consequences – that is until I had one. When waves of grief, regret and self-reproach threatened to engulf me I could only conclude that there was something wrong with me. I was not supposed to feel this way. I felt alone; until I learned that I wasn't. Although everyone's experience is unique, both scientific studies and informal online forums validated my feelings of grief and loss (Toedter, Lasker, Janssen). Yet, the sense of isolation persists for most who make this difficult decision. And this feeling of isolation isn't unique to abortion – most men and women who experience pregnancy loss through miscarriage report feeling the same way (Allen, Marks). In both situations, men and women express a desperate longing for their grief and loss to be recognized.

Prevalence of Miscarriage and Abortion

OK…you say…but what does that have to do with me? That is a very good question, especially when the cultural silence surrounding pregnancy loss leads us to believe that only a tiny minority are impacted. Case in point, a 2015 survey found that most Americans believe that 5% or less of pregnancies end in miscarriage when it's actually closer to 20% (Geggel). With a similar abortion rate, a total of two million pregnancy losses through miscarriage and abortion will occur in the United States this year alone (Oaklander). And, studies indicate that many of these two million couples will silently mourn without the social support necessary to make sense of their loss (Toedter, Lasker, Janssen). According to therapist and grief expert Kim Kluger-Bell, this should concern all

of us (23). Unresolved grief can manifest itself in "chronic depression or psychosomatic disorders" not to mention low-grade sadness that is unnecessarily extended for years or even decades (Kluger-Bell 23-24). It is my contention that as difficult as it is to discuss pregnancy loss, for the well-being of millions of Americans we need to do just that. And not just talk about it, but make systemic changes to break the silence and provide adequate support for men and women struggling after an abortion or miscarriage.

Disenfranchised Grief

College professor David Hlavsa was taken-off guard by the response to an email he sent to students and colleagues after the unexpected death of his unborn son when his wife was 20-weeks pregnant:

> AND then came the outpouring: for weeks after, people I barely knew would come into my office, gently shut the door and burst into tears. I heard stories of single and serial miscarriages, pregnancies carried nearly to full term, stillbirths — all the lost, lost children. Grief hauled about, and nowhere to put it down. Some said they had never told anyone; who would understand?

In an attempt to save himself from repeating the news "over and over," Hlavsa inadvertently tapped into a deep reservoir of hidden pain. While Hlavsa's transparency validated the loss of the men and women who visited his office, most people are still trapped in silence. In many ways cultural attitudes dictate and perpetuate the silence that threatens the well-being of so many.

According to perinatal grief experts, cultural attitudes about miscarriage aren't necessarily spoken. Rather, cultural attitudes are conveyed through various actions and inaction such as the absence of sympathy cards and memorial services (Lang et. al.). Additionally, other grief rituals such as sending flowers, cooking meals and impromptu gatherings of friends and families are generally not practiced. When it comes to places of employment, bereavement leave is typically not given nor expected. In fact, popular culture advises couples to wait to share news of a pregnancy until after the 12th week to avoid the discomfort of people's reactions if the pregnancy ends (Geggel). Unfortunately this practice cuts them off from the support that could be offered if they do in fact lose the pregnancy. When news of a miscarriage *is* shared, typical responses include "You can always try again" and "It was probably for the best." Men and women who show signs of grief months or years after a miscarriage are often advised in so many words to "get over it." Perinatal grief experts believe that these responses fit with the cultural belief that though miscarriage is unfortunate, it is relatively rare and ultimately not that significant (Lang et. al.). *Medical professionals unwittingly reinforce these cultural attitudes by attending to the physical needs of a woman who is miscarrying while ignoring or glossing over the emotional impact on her and her partner (Merrigan)*.

Miscarriage Hurts

In contrast to cultural attitudes about miscarriage and its impact, therapists Marie Allen and Shelly Marks describe a more intense reaction calling for a different response.

In their book *Miscarriage: Women Sharing from the Heart*, they describe the great loss and grief that men and women feel after the death of a child through miscarriage as well as their feelings of anger, guilt, shame and isolation (Allen, Marks). In their personal and professional experience, the grieving process tends to last for years and doesn't ever quite resolve. One of the women interviewed for the book who miscarried 15 years ago, describes the ongoing aspect of grief, "It's a lifelong loss, something you think about through your whole life. You see a child that age and you think about it. You never get over it" (19). A man who lost his son when his wife was 16-weeks pregnant adds, "The pain is still here. It will linger…I don't feel devastated, but I think I will feel devastated on his birthday, at special times, and at other deaths" (103). (Careful not to broad-brush everyone's reaction, Allen, Marks and other grief experts point out that not everyone is devastated by miscarriage, making it important to understand and respect the complexity of each person's experience.) And these grief experiences aren't simply anecdotal stories – they are supported by perinatal loss studies conducted over the past 40 years (Toedter, Lasker, Janssen).

Perinatal Loss Studies, Impact on Men, Complicated Grief

Dozens of studies worldwide using the Perinatal Grief Scale which measures overall grief and the subcategories of active grief, difficulty coping and despair, indicate that men and women experience significant levels of grief after miscarriage (Toedter, Lasker, Janssen). While grief levels are higher for women in all categories shortly after the loss, levels for some men actually begin to rise after the one and two year anniversaries. Researchers theorize that these delayed reactions are connected to the even stronger cultural denial of pregnancy loss for men (O'Leary, Thorwick). This is concerning as the cultural denial of perinatal grief and the subsequent lack of social support, is shown to be one of the most significant risk factors for developing Complicated Grief (Kersting, Wagner). In one study, an alarming 59% of participants showed "delayed resolution of grief" two-years after the loss (Kersting, Wagner). Crippling problems can arise from Complicated Grief including depression, sleep disturbances and difficulty coping with daily living as well as post-traumatic stress disorder and suicidal ideation ("Complicated Grief"). In spite of the fact that it is now "widely recognized that pregnancy loss can lead to psychiatric disorders and Complicated Grief," few resources are offered to couples and follow-up is rarely available (Kersting, Wagner). In addition to the obvious implications, this woeful lack of services further contributes to the cultural attitude that miscarriage is "no big deal" reinforcing the "inappropriateness" of grieving over a "non-loss."

Abortion Changes You

As miscarriage continues to be treated as a non-loss to the detriment of millions of couples, it is not surprising that loss after abortion is even harder to acknowledge. Yet for many individuals impacted by abortion, grief persists. A recent anonymous post to "abortion changes you" poignantly captures one person's anguish in poetry:

> I can't remember the last time I cried
> though my heart is still filled
> with a profound emptiness and longing for someone I haven't even met.
> I don't have to see you to witness your beauty
> I don't have to hear you cry to know your voice
> I don't have to hold you to feel your heart close to mine,
> for it is through the immeasurable void you leave in the world that I will forever know you,
> and through the unremitting grief that I will forever love you. ("Stories")

Dr. William Worden, author of *Grief Counseling and Grief Therapy,* explains that if an outlet isn't found to process loss after abortion, "Grief may appear years later when the woman reaches menopause, or if she believes herself infertile. Such grief often manifests itself as anger or guilt, which results in self-punishing behavior" (136). Kluger-Bell agrees, adding that men can be equally impacted – although they are even less likely to share their feelings (100). "I have known other men in my practice who have discovered many years after an abortion that they still carry a great deal of grief over this kind of loss. There is simply no place for them to speak about it" (Kluger-Bell 116).

Unique Reactions

Certainly the nature of the loss – "chosen" rather than "happened" as in miscarriage – and the resulting confusion about the appropriateness of grieving, can intensify emotions and re-enforce the code of silence. Adding to the confusion is a political debate that narrowly casts personal reactions in terms of empowerment or emotional devastation (Ramos Stewart, et. al. 12). This is especially hurtful when advocates on either side of the issue publicly argue about the "rightness" or "wrongness" of a person's reaction. As can be imagined, this tug-o-war only increases the isolation that men and women feel after abortion and intensifies their fear that they will be judged for feeling "too little" or "too much." Once again, it is important to acknowledge that every person's reaction is unique. As Kluger-Bell points out, although abortion is never an easy choice, not everyone will grieve or regret their decision (70). Because of this she cautions against making "generalizations about the experience of abortion," instead urging that we treat each person and their unique set of circumstances with respect (71). In the midst of the uniqueness of abortion experiences, studies indicate that whatever the circumstances – and even if the abortion is not regretted – some level of grief is common (Toedter, Lasker, Janssen). And, as with pregnancy loss through miscarriage, men and women who lack social support are at risk of developing Complicated Grief (Kersting, Wagner).

Grappling with Miscarriage & Abortion

While this may be the case, some women who have lost a child through miscarriage feel it is inappropriate – even hurtful – to equate loss after abortion with loss after miscarriage. This seems to be especially true for couples who endure multiple pregnancy losses and struggle with infertility. To further complicate matters, it is possible to have both a miscarriage and an abortion in a woman's reproductive history. And, if the

abortion preceded the miscarriage, men and women sometimes feel like they caused the miscarriage or are in some way being punished for their decision to abort. Jeffrey (not his real name), a middle-aged pastor, recently shared that he blames himself for the four miscarriages that his wife suffered:

> We seriously considered aborting the first pregnancy, so when we lost the child before we could carry it [the abortion] out, we felt that we caused it. And then after each of the other miscarriages, I thought that we were being punished because I failed to protect our first child. The grief and guilt were unbearable – they still are sometimes. (personal communication, 2016)

In addition to self-blame for pregnancy losses, Kluger-Bell suggests that "some women probably fear that if they speak too loudly of their grief following early miscarriages they will give fuel to the anti-abortion movement" (20). These are just a few examples of how the complexities surrounding loss after abortion and miscarriage feed into cultural silence about reproductive grief and loss. However, to remain silent is not an option when so many men and women are hurting.

Breaking the Silence

So what can we do? As suggested earlier, openly discussing these issues will go a long way toward breaking the cultural silence. Needless to say, this can be very challenging. It certainly is difficult to talk about intensely personal and private matters – especially when they are so often imbued with layers of unresolved grief. And just bringing up abortion – even in the most compassionate and respectful way possible – can easily devolve into a shouting match. However, when we focus on the individuals involved and stay away from politically charged terminology, I have found that people are willing to talk about how pregnancy loss has impacted themselves or someone close to them. Among other things, creating an environment that feels safe to talk about pregnancy loss normalizes the grief experience and lets people know that they are not alone (Zamudio). Of course, once this sense of safety is created, it is important to know what to do if someone shares their loss. In addition to active listening, in most situations making simple statements like "I'm so sorry for your loss" and "I'm sorry you are going through this" acknowledges the reality of the loss and signals that it is okay to grieve (Ramos Stewart et. al. 48). And, after you learn of a pregnancy loss (even if it's many years later), sending a sympathy card and remembering the anniversary of the loss provides support for the couple and models different behavior for others to emulate.

Role of Medical Professionals

In addition to the support that individuals can lend to one another, systemic changes in the medical field are sorely needed. In spite of studies revealing that the reaction of medical professionals to a pregnancy loss sticks with the parents "forever" and influences how they cope with the loss, adequate training is rarely provided (Lang, et. al.). I first learned about this lack of training from a third-year medical student who shared a troubling situation encountered during her rounds. Karen (not her real

name) discovered that a patient who had miscarried was moved to a private room at the far end of the floor because the staff was uncomfortable with her "constant crying." According to Karen, the staff did not acknowledge the patient's loss nor were there any plans to provide after-care referrals. Karen wanted to help, but was unsure what to do (personal communication, 2008). Unfortunately, Karen's lack of preparation and the situation she described is far too common (Harris). Registered nurse and bereavement care coordinator, Joyce Merrigan, points out that the fear of saying the wrong thing often prompts nurses to say nothing even though "saying nothing may be as harmful as saying the wrong thing." Fortunately, nurses and other medical personal can overcome their fear and gain the confidence to say the "right" things through training and the adoption of evidence-based protocols. According to registered nurse Janice Harris, it is of paramount importance for healthcare providers to acknowledge the loss of the child during a miscarriage and to allow – even encourage – the parents to cry. Additionally, informing parents about what to expect during the grieving process and providing referrals to bereavement support groups will help to prevent isolation and the development of Complicated Grief (Harris). Grief experts also emphasize that men need to be included as they tend to get overlooked making them particularly vulnerable to experiencing delayed grief reactions (Kersting, Wagner). In the words of one grieving father, "A few times I could have spoken to people about things, but I wasn't asked so I never said anything" (O'Leary, Thorwick).

The role of medical professionals in loss after abortion is less clear, although acknowledgement of the loss and the provision of resources is a good place to start. Access to online forums such as "abortion changes you" can also be helpful. Researchers have found that web-based healing resources provide benefits for hurting individuals including the reduction of social isolation, round-the-clock access, and meaningful activities to work through the grieving process (Geller). Researchers also believe that there is great value in providing these types of self-directed resources as they empower visitors to "tap into their own natural resilience" (Geller). Mental health professionals can also do their part by seeking out training and information about pregnancy loss after miscarriage and abortion. Something as simple as inquiring about pregnancy losses during client intake sessions communicates that pregnancy loss is a significant life event and opens the door to future exploration if the client desires. Medical practices and cultural attitudes will not change overnight. And breaking the silence about pregnancy loss may be a rocky, painful journey for everyone involved. However, for the well-being of millions of Americans, it's a journey that must begin.

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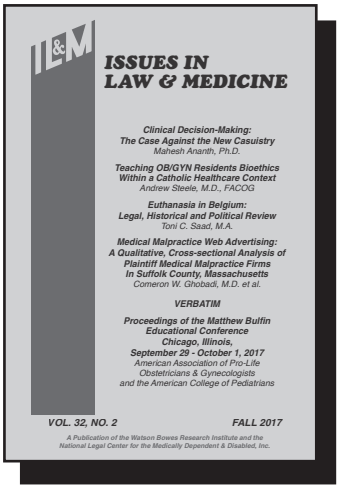

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