Her real name was Stephanie Fae. Her 23-year-old mother, Teresa, withheld the name “Stephanie” from the press because “reporters dig too much and they might find out her last name also.” Details such as this abound in a long interview with the parents of Baby Fae as printed in two consecutive issues of People magazine (“Baby Fae: A Child Loved and Lost,” Dec. 3 and Dec. 10, 1984). The reading of this interview simplifies the task of discussing the professional responsibilities of physician-surgeon Leonard L. Bailey towards his tiny client and her parents, for it reveals an unusually warm, open and supportive relationship between the physician and the parents.

Theologian Richard McCormick, S.J., was right to ask the question (as printed in the Nov. 18, 1984, issue of Our Sunday Visitor, p. 5); “Is this a therapeutic procedure? Or are they tinkering around with a dying baby?” Dr. Bailey’s expertise is in the area of animal to animal transplants. He had been involved in 150 such procedures, and believed that the animal transplant for Baby Fae could significantly improve the infant’s chances for survival because of her relatively under-developed immune system, and because of the availability of the powerful immunosuppressive drug “cyclosporine” which could fight the possible rejection of the graft (Science News, Nov. 3, 1984, p. 276). This procedure would “buy” time until a suitable human heart was found. In an interview with the American Medical Association publication, with obvious reference to his research and experience in the science of “developing animal hearts that are compatible in cell and tissue structure with the recipient,” Dr. Bailey said:

“For the start of this formal project 14 months ago, we have clearly insisted upon a therapeutic intent. This is not simply experimentation for experimentation ... I suppose we could have used a human heart that was...}

(continued on page 2)
possible longevity and "quality of life" prospects for the infant;
(3) An adequate background for exercise of informed consent.

(1) Options with their Benefits and Risks

Dr. Bailey knew of a possible alternative for the treatment of Baby Fae which had been pioneered by Dr. William Norwood (presently at the Philadelphia Children's Hospital) and his colleagues. This two-step surgical procedure had been tried on 100 infants in Boston and in Philadelphia "with about a 50 percent survival rate to date." The oldest survivor is now a relatively healthy four-year old (Science News. Ibid.) In the interview with the parents of Baby Fae, the mother, said:

"He explained the Norwood operation, said we could take Fae to Philadelphia right away for that . . . . Since I thought it was only temporary, I did not consider it. He showed me slides that showed me exactly what went on in this operation" (People magazine, Dec. 3, 1984, p. 56).

Teresa then asked about a human heart transplant. Again, the actual response of Dr. Bailey, as understood by the mother, is of prime importance:

"He said it was very rare for a human heart of such a young age to be available at just the right time, whereas baboons were plentiful and they could do those tests for compatibility and find one that was a really good match" (Ibid.)

In answer to an inquiry about an artificial heart, Dr. Bailey explained that the rapid growth rate of an infant would require other operations to change the size of the artificial heart "through her young years." After showing "a lot of slides of a heart operation he had performed between a sheep and a goat," Dr. Bailey gave the couple some pamphlets (a few of them unpublished) on such experimental operations. He was frank in speaking of the side effects of the drug cyclosporine which would have to be administered to Baby Fae to prevent rejection of an animal heart - that it could cause kidney failure. Teresa added:

"He repeated that there was no guarantee of anything at this point" (Ibid.)

It should be mentioned, for the record, that the heart of a two-month-old infant was available the day of Fae's operation. Officials of the Loma Linda (Cal.) Medical Center stated that the call from the procurement agency had come after the baboon heart was implanted, and that the heart of a two-month-old might have been too big for Baby Fae. Surgeon David Hinshaw of the center explained that he and his colleagues believed that "the hope of finding a compatible human heart in time to save the dying Fae was "almost nonexistent" (Time, Nov. 12, 1984, p. 72).

(2) An Honest Appraisal of Longevity and "Quality of Life"

Honesty, in view of the history-making surgical transplant proposed for Baby Fae, would have to mean NOT making any promises as to longevity or "quality of life." The intervention of Dr. Bailey and his colleagues added three weeks to Baby Fae's anticipated life span. Baby Fae was born in Barstow, Calif., on Oct. 12, 1984. That same afternoon, the authorities at the Barstow hospital had the infant transferred to the Loma Linda Medical Center (some 90 miles away). The mother did not believe the doctor when he told her that Baby Fae was a victim of the very rare infant-heart defect known as hypoplastic left heart syndrome (found in about one in 12,000 newborns in the USA), and especially when he told her that Baby Fae was dying and "there was nothing they could do for her" (People magazine, Dec. 3, 1984, p. 54).

They spent a long night (until "5 a.m. or so") in conference with Dr. Bailey. In the words of Teresa: "He told us there were no guarantees that she would survive, no matter what we did. Then he told us all the possibilities" (Ibid., p. 56). Here is where the "quality of life" consideration took on an altruistic turn. Driving back to her home town of Barstow, Teresa was mindful of the fact that the operation proposed by Dr. Bailey "had never really succeeded," but sought comfort in another scenario: "But here was this chance for her to live. And I thought about the other babies that might get a chance to live with this operation" (Ibid.).

Howard and Teresa (parents of Baby Fae) were under no illusions about the risks involved in Dr. Bailey's proposal.

(3) The Issue of "Informed Consent"

How could an adequate basis for informed consent be available to the parents of Baby Fae when Dr. Bailey's expertise in transplant procedures had not been established through publication in prestigious medical journals. Actually, Dr. Bailey had published at least 30 articles of various aspects of pediatric heart surgery. His colleague, Dr. Provonska, at the Loma Linda Center explains the lack of publicity on Dr. Bailey's research in transplants by saying: "He has tried to get published, but the procedure was so novel that prestigious journals would not print his articles" (Newsweek, Nov. 12, 1984, p. 115). The salient fact is that the parents of Baby Fae had faith in Dr. Bailey, and were in no way pressured to agree to his proposal. Teresa said:

"Also, I started feeling good about it because of Dr. Bailey being direct to the point, confident, compassionate. And with seven years of research behind him" (People Magazine, Dec. 3, 1984, p. 56).

Both Howard and Teresa testify to the lack of any pressure to agree to the proposal of implanting a healthy baboon heart in Baby Fae. Howard said: "They gave us all kinds of chances to back out of the whole thing - we could have stopped it right up to the time she was in surgery - but I can tell you I never once considered that" (Ibid., p. 57). Two days before the surgery (with an attorney and two witnesses present along with Dr. Bailey) they signed the first consent form. The Loma Linda Center urged a second signing of the consent form which took place the next day - apparently towards evening on the day before Baby Fae's surgery. Following this second signing, a priest baptized Baby Fae "right in her room using sterilized water" (Ibid., p. 58). Considering the circumstances, the "informed consent" requirements were in no way neglected.
Dr. John Collins, chief of cardiac surgery at Boston’s Brigham and Women’s Hospital, reflected the sentiments of many admirers of Surgeon Leland Bailey when he said: “It’s very easy to sit back and be negative when a new treatment is announced. If we all were afraid to attempt the untried, we would have no new treatments.” (Time, Nov. 12, 1984). Baby Stephanie Fae did not live and die in vain. Her physician, Dr. Leland Bailey, gave her due credit for her significant contribution to human progress when he said:

“Infants with heart disease yet to be born will some day have the opportunity to live, thanks to the courage of this infant and her parents. We are remarkably encouraged by what we have learned from Baby Fae” (Time, Nov. 26, 1984, p. 88).

Director of Research

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Isolating The Threatening Womb

Is It Contraceptive Sterilization?

The teaching of the Catholic Church regarding the sterilization of a woman’s basically healthy reproductive system is well known. When such a sterilization is in reality an effort to avoid pregnancy from sexual actions which a wife intends freely to pursue, simple honesty bids us call such surgery by its right name: contraception. Similar to the use of barriers (condoms, diaphragms, spermicides, etc.) and other contraceptive methods, it constitutes an attack (by anticipation) on the conjugal act, the language of the body by which God intends a couple to say “yes” to each other and to any new life which God may wish to give. To incapacitate a healthy reproductive system specifically in order to avoid a pregnancy from freely chosen sexual activity is to turn that “yes” into a resounding “no”.

The Broken Womb — A Threatening Womb

But what if the reproductive system is not basically healthy? What if, for instance, the uterus has been so traumatized by past cesareans that a physician, performing the most recent cesarean, sees clearly that, in his honest judgment, it would be irresponsible to expect this uterus to carry another pregnancy even to the point of viability? What if another pregnancy can end only in the loss of the fetus and a dire threat to the mother’s life or health because the uterus will rupture?

The reflections in this article regarding removing or isolating such a uterus are presented here, not as an apodictic claim that such procedures are unquestionably compatible with Catholic moral teaching, but rather to provide a stimulus for physicians, moralists, and, if necessary, ultimately the Church itself to examine and judge the question.

Removing the Broken Womb

Whether, when, and with what certainty such a prospect faces the obstetrician and his patient is the competency of medical experts, particularly and uniquely of the attending physician. The morality, however, of removing such a basically broken womb must be judged by sound ethical principle, seen and strengthened for the Catholic by the light of the Gospel and the way of life given by the Church by Christ and His Spirit. Since at least the 1950’s, moralists have wrestled with the question: Is removing such a seriously damaged uterus a contraceptive act? Or is it rather an act of responsible stewardship of the body, a stewardship the Lord expects of us?

Despite hesitation from some leading moralists,1 a number of moralists widely known for their adherence to the Church’s moral doctrine have probed the question without any obvious, open objection from Church authorities.2 Many would note that when an organ has lost any inherent usefulness (e.g., the appendix), one may legitimately remove it. A fortiori this would be true when the organ, by reason of its own pathology, has developed an inherent serious threat to life or health. This removal, they would maintain, is an application of the principle of totality. Hence, according to them, hysterectomy in cases of the type discussed here could be justified, and would not be contraceptive in nature.

Isolating the Broken Womb

Thomas O’Donnell in 1967 chronicled this development approvingly, indicating also another logical step in the analysis he and others were exploring.3 Instead of removing the basically damaged uterus (e.g., in the process of a cesarean section), would it be ethically acceptable for the physician simply to isolate it by tubal ligation? To sharply distinguish this procedure from the sterilization of a basically healthy reproductive system, O’Donnell and others use the term “uterine isolation.”4 Such a procedure would avoid the far more invasive and traumatic total hysterectomy, as well as the resulting increased post-operative complications, such as adhesions. Many (not all) theologians who accepted the removal of a damaged uterus accepted also this uterine isolation.5 Some have pointed out that the fallopian tubes would have to be cut or removed anyway as the damaged uterus was being removed by hysterectomy. Why should the physician be obliged then to proceed to further damage the woman’s body by actually removing the isolated uterus?6

Church authorities have never clearly and explicitly addressed the issue of uterine isolation. Some moralists opposing the procedure have pointed out, however, that Pope Pius XII, near the end of his life, did speak to another issue — anovulant drugs — which would seem logically to have unfavorable implications for uterine isolation:

One is provoking a direct sterilization, and one which is therefore illicit when one halts ovulation for the purpose of saving the uterus and the [whole] organism from the consequences of a pregnancy which the uterus is not able to bear.7

The Pops did not elaborate on the meaning, reasons or further implications of his statement, and it remains for many somewhat