Report from America

Bernard Towers *University of California, Los Angeles, USA*

The trials of Dr Waddill

William B Waddill, MD was and is a gifted and highly successful obstetrician/gynaecologist from Orange County, which is one of the most conservative communities in California. He has twice had to face trial on a charge of murder of a premature infant, delivered on 2 March 1977, as the product of a second-trimester saline abortion. The court trials were only a part of it: Dr Waddill's offices were frequently picketed by members of 'Right-to-Life' groups and by school-children carrying placards denouncing him; from pulpits all over the area he was repeatedly vilified over a period of two whole years; media accounts were sensational, to say the least, especially at the start, and it is remarkable how many people on hearing Dr Waddill's name, will still say 'Oh yes. Isn't he the one who strangled a baby?'; his hospital privileges were for a time curtailed; and the costs to him in terms of time, money and emotional and physical energy were enormous.

Both trials ended in a 'hung jury': at the first, in May 1978, the jury voted seven to five in favour of acquittal. In this year's trial the vote (July 1979) was eleven to one. Theoretically he could have been brought to trial a third time. But the judge dismissed all criminal charges against him, and wisely said, 'There comes a time in legal matters, as in medicine, when one must pull the plug'. The plug was pulled, of course, on the Deputy District Attorney, Mr Chatterton, who had pursued this case like a zealot, pumped up throughout by the 'right-to-lifers' with all their energy, money and their considerable and growing political clout.

On 2 March 1977, Dr Waddill carried out an abortion procedure (250 ml of 20 per cent saline in aliquots of 50 ml with withdrawal of similar volumes of amniotic fluid) on a seventeen-year old unmarried schoolgirl, daughter of a headmaster. Dr Waddill had previously obtained the 'informed consent' of both the girl and her parents. By dates she was twenty to twenty-one weeks of gestation; she was still wearing her regular jeans and was not showing much outward sign of pregnancy; by physical examination the estimated gestational age was twenty-two to twenty-three weeks.

An apparently dead fetus, unexpectedly weighing between 1100 to 1200 grams (twenty-six to twenty-eight weeks) was delivered thirteen hours after the

start of the procedure. This is much sooner than the normal twenty-four to thirty-six hours by which time a fetus is not only poisoned, as a result of its continual imbibing of concentrated saline, but is dead to the point of maceration on occasion. A nurse put the fetus in a paper-bag and took it to a side-room to be placed in formalin. However, a twitch of a limb was noted, and the fetus was seen to make occasional feeble gasping movements. Heart rates of between sixty to eighty per minute were noted, and the fetus was rushed to the neonatal ICU and placed in an isolette. A resuscitation team was summoned, which included an Emergency Room physician-resident. A phone call to Dr Waddill brought the response 'Do nothing except give oxygen'. He arrived on the scene ten minutes later, some twenty-five minutes after the blue and flaccid fetus had been found in the mother's bed. The team had done a little external cardiac massage - for what reason is not clear, unless it was judged (and almost certainly correctly) that the heartbeat was not generating an effective cardiac output. Ineffective bagging with an oxygen enriched (40 per cent only) atmosphere had also been done. One person in the team had suggested intubating but no-one had acted. No attempt had been made to place an arterial line, so that all judgement as to 'alive or dying or dead?', and the prognosis as to viability (*ie* survivability) in light of the saline-poisoning, had to be on the basis of clinical knowledge, clinical observation and clinical experience. A nursing-supervisor with no experience in neonatology, and a paediatrician with no experience or knowledge of the effects on a fetus of a saline-abortion, made a number of suspect 'observations' and arrived at a number of faulty judgements. It was they who informed the police and initiated Dr Waddill's two years of trial by ordeal.

Dr Waddill had dismissed the resuscitation team and had called the attending paediatrician to confirm his judgement that the fetus was dying or dead. Meanwhile he palpated the trachea in case the paediatrician wanted him to intubate, and felt for carotid pulses to enlarge his data-base. These actions were what the paediatrician later testified to as 'attempts to strangle the infant'. It was also said that Dr Waddill had called for a syringe of potassium chloride in lethal quantities. This testimony went unchallenged (except by Dr Waddill) at the first trial, because the ICU nurse declined to testify. It

subsequently transpired that the prosecution had warned her that if she testified for the defence and if Dr Waddill was convicted she would be liable to prosecution as an accessory to a crime. Before the second trial she obtained immunity from the presiding judge, and her eyewitness testimony directly contradicted, in many respects, that of the prosecution witnesses.

In situations of life and death, where emotions run high, and where philosophical predilections and religious beliefs are stirred to the depths, it is always difficult to attain objectivity in observations and in conclusions. At the first trial the defence introduced a number of expert medical witnesses, one of whom was a paediatric neurologist who testified that, given all the circumstances (extreme prematurity, the toxic effects of saline, the duration of severe hypoxia or anoxia) the fetus must have suffered brain-death, so that a beating heart, or occasional muscular twitches, or a weak 'gasp' every fifteen seconds, were irrelevant in a jurisdiction that recognises brain-death. It was felt that this testimony probably changed an uncertain jury from a majority for conviction into a majority for acquittal.

At the second trial the defence introduced a larger number of expert medical witnesses from all relevant fields. It was difficult to see, at first, how testimony could be introduced concerning the quite different ethical duties and responsibilities of a physician when treating a viable (survivable) patient as compared to treating a non-viable and/or dying patient. Your correspondent's testimony in these and other philosophical regards could be introduced only after much examination and cross-examination about the biological phenomena. Demonstration of 'expert knowledge', based on clinical experience, on experimental laboratory studies on immature mammalian fetuses of other species, and on many years of teaching the subject 'Development Before Birth' permitted the questioning eventually to move into the complexities of clinical judgement-making and possible rationales for actions based on such clinical judgements. It is essential, in the writer's opinion, that physicians be not only well-trained in, but also well-practised in, making such analyses and in defending the conclusions. Too many doctors function unreflectively by rote, using a 'how to' approach which tells how to react to specific situations by invasion, in one form or another, of the patient's right to privacy. True reflection, on the other hand, often suggests that action is better than reaction, especially when the appropriate act is one of omission rather than of commission.

The Waddill case did not attract the nationwide attention that Dr Edelin's trial did in Boston a few years ago. Even in California, the second trial attracted media-coverage only in the region that includes Orange County. The National *Right-to-*

Life News, however, covered the case virtually every month. Distorted accounts and malicious charges have appeared repeatedly in this newspaper for the last two years: the July 1979 issue carried a fairly restrained account of the conclusion of the trial, and of the dismissal of criminal charges against Dr Waddill; but disappointment at the outcome is obvious in the two brief articles that deal with it.

The struggle between the opposing groups on abortion (*Right-to-Life v. Pro-Choice*) is being increasingly politicised by the former faction. Opinion-polls continue to show that a large majority of the people in the US approves the Supreme Court's 1973 ruling on the legitimacy of abortion-procedures under prescribed conditions. But a growing campaign is pressuring candidates for public office at all levels to declare themselves on the abortion issue, and especially on the question of public funding of abortion for the poor. If the candidate's response is 'unsatisfactory' on this one issue then, irrespective of his/her responses on the other thousand matters that are of public concern, campaigns may be mounted to defeat the candidature. If, as seems unquestionably to be the case, it is primarily a religious motivation that drives the anti-abortionists, and if this religious attitude is calculated to disrupt the political process at all levels, then the famous US principle of separation of Church and State looks like it is being placed in jeopardy. Moreover, active anti-abortionists tend to be overly prejudiced on other issues. Prejudiced legislators do not, on the whole, enact good laws. The democratic process which allows for representation of all interest groups can be readily thwarted by a well-organised and well-orchestrated pressure-group. The 'war against abortion' is well and truly on. Its political implications, as America moves further and further to the Right, are frightening. If and when the Supreme Court's 1973 ruling is either revised by the Court or is declared unconstitutional (and the forces of opposition to it are fighting battles on all fronts) we shall not simply return to pre-1973, because the momentum gained will be channelled into other causes of the Right. The movement may have lost a battle over Dr Waddill, but the war goes on.

It would be nice to think that some reparation might be made to Dr Waddill by the 'do-gooders' who attacked him so violently and tried so hard to destroy his life and livelihood. But religious passion of this kind knows little of the virtue of compassion. One can imagine them saying he was 'lucky to get off' – and feeling very angry about it, to boot. So, one can only wish Dr Waddill a speedy recovery from trauma, and express the hope that his dedication to the practice of good medicine will more than compensate for the many trials to which he has been subjected.