Andre E. Hellegers, M.D.

Reflections on Health Care and its Possible Future

It is a distinct pleasure for me to have been invited to join you in this celebration of the 10th anniversary of the Loyola Medical Center.

A 10th anniversary can be an occasion for looking back. It can also be one for looking forward. I intend to do both. I intend to review what has happened to the meaning of the words “health” and “disease.” I shall then look at what will happen to the demography of the United States within the foreseeable future and from these data I shall speculate on what we might do to alleviate the problems which face us.

It was in the year 1932 that I decided to become a doctor. My mother had been a nurse and my grandfather and great grandfather were surgeons. Since I was all of six years old, I shall not bore you with a lecture on “informed consent” in the making of choices on what to do with one’s life. I do, however, clearly remember what I thought my life would be like because I had a very clear idea of what the words “disease” and “health” meant and no one contradicted me at that time.

1st Definition: A disease was an inflammation, a degeneration or an injury which, if not reversed by my skills, would lead to further inflammation, degeneration or injury and possibly even to death. My patients would have symptoms, probably pain among them, and I would save their lives and take away their pain. I had a vision of a somatic, symptomatic, model of disease although I did not know the meaning of those words then. My patients would surely be grateful to me for my good deeds and I had never heard of the word “malpractice.” This naivete was still with me when I entered medical school in Edinburgh at the age of 18.

2nd Definition: After only a short time in medical school I came to learn that there were people concerned with medical affairs who were not internists, surgeons, gynecologists, pediatricians or other such noble creatures. They were called epidemiologists and biostatisticians. And they had standing beside them others who worked in laboratories and who performed tests on all sorts of body components, mainly fluids like blood and urine. It was their contention that there were people with diseases, without knowing it. Their models of diseases were somatic, but asymptomatic. Often the diseases were known by the prefixes “hyper” and “hypo.” There was hypertension and hypocalcemia, hypothyroidism and hypercholesterolemia.

In brief, they seemed to postulate that somewhere, somehow, there was a normal little chap always weighing 70 kg., whose initials were “EU,” and all of us differed from him to some extent by age, by sex, by size, by predisposition or by a process of inflammation, degeneration or injury already begun, but not yet recognized. If we differed statistically significantly, we too had a disease, although we
didn’t know it, or not yet. Now, such a construct of disease clearly did not appeal to me in my youth. How could patients be grateful to you either for receiving bad news about their future, or for being cured of something they did not know they had, either before or after the “cure”? It is rather like being praised as a good citizen for paying a tax you did not know you owed.

Little wonder, then, that in one’s youth one is more interested in supporting the first definition of disease, rather than the second. The prevention of something always seemed less urgent than the curing of it, whether it be in smoking, in sex or in medicine. As one grows older one becomes more interested in having one’s diseases prevented, rather than cured, but by then it is frequently too late. Suffice it to say at this point that it is the difference between these two models of disease which causes many discussions on how to divide up the health dollar between cure and prevention.

3rd Definition: It was not until late in my medical studies that I found out that there was a third model of disease in vogue. It was espoused by psychiatrists. In this model it was not sufficient to be devoid of the diseases in models one and two. To boot one had to be able to function in society. This was a functional, rather than a somatic model of medicine.

I do not fully know how we came to accept this model and definition with such equanimity. It began, I think, with knowledge of the nervous system and the specialty of neurology. When it became known that there were somatic diseases of psychic origin I suppose it seemed logical to take psychosomatic medicine under our medical wing. After all we had responsibility for the somatic already. However, as we all know, we extended our domain into a category of conditions without somatic components and thus we clasped the whole of psychiatry to our medical bosom.

I need not tell you how immensely this third definition of disease — the inability to function in society — has complicated our professional mission. For the concept of psychiatry raises inevitable questions, depending on how far we take it. Let me raise a few simple questions: Must a person be made functional in any society? If you have a superb Jewish nose, perfectly capable of drawing in oxygen and blowing out carbon dioxide, but having to function in a Nazi society, do you then call the nose diseased or the society? Under what definition or notion of disease do you then do a rhinoplasty? You may say this was a Nazi aberration and not applicable to our enlightened societies.

However, as you know, every year there are in the U.S. literally thou sands of people with facial wrinkles, sagging breasts and behinds, and noses not to their liking who undergo surgery to have their appearances changed not because their tissues are diseased under my first definition, but because they have to function in a society with a phobia about aging and with certain notions of beauty. It used to be said that “beauty is in the eyes of the beholder.” If we now consider absence of beauty a disease, it becomes clear that “disease” is now in the eyes of the beholder. What does that say about the function of medicine?

It is not only aesthetic conformity which can now call upon the skills of the biologist; the same is true for social and political conformity. Crime is often thought to be the proper sphere for medicine. In Russia political deviants are handed over to the medical profession. The problem is not confined to the U.S.S.R. In 1964, 1000 or so American physicians, signing their names with the letters “M.D.” behind it, pronounced Senator Goldwater of Arizona unfit for the presidency of the United States. I am sure the statement was more reflective of the doctors’ social views than of the Senator’s “medical” condition. Fifteen years later in 1979 Senator Goldwater is still in the Senate and much beloved, now often cited as a model of stability in an unstable world.

I have a private dream of being a surgeon in an American Indian community with high respect for age and being very busy as a plastic surgeon,
putting wrinkles into faces instead of taking them out for people who respect the wisdom of age. We are all aware of the massive use of psychopharmacological agents. If you are too down we shall give you an upper; if too up we shall give you a downer. It used to be that we were taught that the first medical ethical principle to follow was a simple one: “Primum non nocere.” What has become unclear is whether we mean “Primum non nocere patienti vel societati.” Is society for persons or are persons for society?

I can clearly recall that we used to get a lecture as medical students by a British guru, usually in a white coat, usually with a moustache, preferably with a knighthood, who would tell us how dangerous it was to treat the symptoms of patients without knowing what the underlying disease was. That was called “masking the disease.” I have the distinct feeling that we are today, as physicians and biologists, increasingly engaged in masking social diseases by treating their symptoms, biologically.

**4th Definition:** If you have followed the chronology of my life and education up to now you will have calculated that I entered the study of medicine during World War II. When the war ended great hopes rested on the creation of the United Nations. One of its many activities was to be in the field of health. By the time I finished my medical education it was clear that there was going to be a major world health organization. Most people knew what a world was and many had notions of what an organization was. At issue was what health was. As befits any organization of this kind a committee was established to define the word. The committee was heavily weighted with public health and mental health figures. It came up with that most extraordinary definition of the word “health” as: “Not the mere absence of disease, but total physical, mental and social well being.”

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“How strange it seems today that the word doctor does not really mean technician but teacher . . . .”
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I am not in any way opposed to the definition. Indeed the state to be achieved was one which closely approximates the one which was promised to me by Catholic priests in my parish in Holland if I stayed out of moral trouble. The only difference is that the priests wanted me to aim at it for the hereafter, whereas W.H.O. wants me to reach it in the here and now. In my youth they assigned the task to the clergy; in modern Geneva they assign it to the medical profession. It reminds me for all the world of a story from my youth: A priest and a doctor were travelling in a car at 80 miles per hour when they crashed head-on into a tree. The last words of the priest were: “Get me a doctor.” The last words of the doctor were: “Get me a priest.”

I have visions, as a doctor, of a patient who comes to see me. Her complaint is that she does not feel well socially because she has a Vega, while her neighbor drives a Cadillac. She asks me to prescribe a Cadillac so she may feel socially as well as or better than her neighbor. If the W.H.O. definition of health is to be the task of the medical profession, it might make sense.

The famous American psychiatrist Karl Menninger wrote a book called: What ever Became of Sin? Should guilt feelings be treated chemically as incompatible with W.H.O. health? In the final analysis: Should we have a crash program to produce Aldous Huxley’s famous drug called soma? You remember it can neither cause death by overdose, nor does it have side effects. Its only function is to make you impervious to your own trouble or that of others.

If we are to seriously assign all four of my definitions to the medical profession we, in essence, make it responsible for providing infinite life in infinite happiness, or heaven on earth, to use an outdated phrase. The American pediatrician and medical administrator Robert E. Cooke has called it “the discomfort-free society.” We are not to be surprised, then, if medicine is occasionally—or increasingly often—asked to positively induce
death. It is, after all, the only “discomfort-free state”—at least if you do not believe in a life hereafter. Clearly a key philosophical question is the age old one: “Is there any role for suffering?” I suggest that, unless our philosophers and theologians address that question with intelligence and cogency, they shall be asked to move over and leave the field of living to biologists.

I wish to turn now to the second part of my talk. If indeed we as biologists shall be held responsible for best approximating the proposition of eternal life in total happiness here on earth, then we have a problem of allocating resources, for we shall have an infinite task to solve with finite resources. How can we best allocate these resources? In the U.S. the usual first step in answering such a question is to refer it to Washington. There we stick it in a computer, but the question is how we shall program it.

Let me suggest to you that there are developing two schools of thought on how to program the computer. The one school espouses an ethically deontological methodology. It insists the governing principles should be equality of access, fairness, justice—in brief a rightness of means. This school is led by public health officials, lawyers and politicians. Often ethical principles of distributive justice are adduced as the Bible. Such people often stress the need of caring above that of curing.

The second school could be called the teleologist. Most often they are represented by the “hard scientist.” They ask what is the end or purpose of the medical profession. They hold the same view of medicine as I did when I entered the profession. Our function is to save lives. That sounds simple and correct, but it is my thesis today that it is more complicated than many think—how shall we define and value a saved life?

The first unit of measurement simply deals with “lives saved.” Let me postulate a problem with that unit by describing a case. A man has terminal cancer of the lung and all experts agree he has about one week to live. He is in severe pain. Suddenly he has a cardiac arrest and will be dead in five minutes instead of one week. Should a doctor begin cardio-pulmonary resuscitation to prevent him from dying through cardiac arrest, so that he will die next week of his cancer after more pain? Is the computer to count the cure of the cardiac arrest as one life saved?

Some would answer no, indeed many would. They would insist on a mathematically more “sophisticated” model and ask that we consider life years saved. In this way one week does not count for much. But life years has problems too. Consider the problem of Karen Ann Quinlan. She went into an inexplicable coma and was attached to a respirator. After a long trial it was permitted to detach her from the respirator and she continued living. She has now been in coma for four years and there is no one who believes she will ever regain consciousness. Should the computer, under the rubric “life years” saved consider this a four year success story?

So some again say no, indeed many do. They would abdicate the units of weeks, or months and of years and speak of life quality years. But computers can only handle quantitative data, not qualitative ones which are subjective, and so we should have to attach numbers to quality.

For this reason some would use the unit “life productive years.” But how should we measure “productivity”? In terms of love produced, friendship produced, care consumed or what? What is the unit of measurement? It is at this point that an “expert,” called a “cost/benefit analyst” is often introduced. He is no better than you or I in quantifying the affective. He only asks what is effective. Usually the dollar is his god. It is cheaper to abort the fetus than to deliver it, he would say. Quite right—providing you ask no questions about discount rates. The old, especially with compulsory retirement laws, will for the rest of their
lives consume more dollars than they will produce. Health care for them therefore becomes indefensible. Ultimately this approach runs smack into the final question: What price a life?

I do not know whether you, in Chicago, have the same debates as we do in Washington about smoking,. Irate bureaucrats will tell you that by smoking you run into health problems which require care and cost money. You are irresponsibly increasing the cost of health insurance they say. Maybe so, but I am far from sure about it, depending on what laws exist and how the computer is programmed. If the dollar produced or consumed is to be the unit by which equity and effectiveness in health care allocation is to be judged, then I might suggest that we should strongly encourage all such patterns of behavior as will kill us most closely to the day of our retirement. Under such a construct smoking and heavy drinking might well be the most “effective” behavior in cost/benefit terms. We shall have contributed the most dollars to the common economy and consumed none through retirement.

Let me at this point—still focusing on the cost/benefit ratio with the dollar as the unit—ask about another problem in allocating resources, which stems from what is happening to us demographically. I shall summarize several demographic facts. The first fact is that the birth rate has fallen to 15 per thousand today. Remember that these children become the work force of the future through whose taxes health care will have to be financed.

The second fact is that life expectancy is increasing. In 1900 life expectancy for white males was about 48 years and for females about 51. Today it is about 70 for males and 76 for females. Black and other populations lag about five years apart. Largely these figures are due to fewer deaths at the beginning of life. Once we reach 65, success in increasing the life span has been less spectacular with a gain since the second World War of less than two years for white males and 4.5 for females. For blacks these increases are about two years for males and 3.5 for females.

What do these figures tell us? They tell us that we live longer— that with fewer children the future work force will not be as large as it would have been with higher birth rates—and upon this we must reflect to see how the relationship will be between the working tax producer and the old tax consumer. Let me cite a few facts:

1. In 1930 the 65+ age group was 5.4, today it is 10.8% of the population.
2. The fraction in the work force has remained constant at 65%.
3. The fraction of children under 15 has gone down from 29.3 to 23.8%.

What this means is that in 1930 there were 12.1 workers for every retired person, today it is 6.1—or half as many. In other words per worker the financial burden of retirement is twice as great. By 2025 our baby boom children will have retired and then, given no change in fertility, we shall have 3.54 workers per retired person. Let me repeat: It was 12.1 workers per person over 65 in 1930, it will be 3.5 in 2025 and we are half-way there in time and number, with some increase in longevity making the problem yet more acute.

The question is obvious: Do we really have a medical establishment geared to our future task? I suggest we do not. Our success in increasing life expectancy is the result of high technology medicine. Clearly that technology has not been as successful beyond age 65. Life is at present genetically—and species specifically—limited and towards the end of our life a so-called cure simply means exchanging one form of dying for another.

What it all means is that as the birth rate drops, as the perinatal and infant death rates approach zero and our
people individually and collectively age we are left with a model of medicine which is less and less applicable to the real facts of life—or should I say of death? To assign all four of my definitions of health as a task for medicine to resolve through the high technology of today becomes an absurd proposition. Increasingly our new task shall be to add life to the years and not years to life. It is not quite clear at what rate we shall have to switch from the cure to the care mold of medicine. But I suggest that by the year 2000 the dilemma will be crystal clear.

A final word about my thesis as a challenge to medicine and especially to Judeo-Christian medicine. We have, as Jews and Christians, always asserted the existence of a life hereafter. I suspect we have done that in our origins more as a caring community than as a curing one. How strange it seems today that the word doctor does not really mean technician but teacher and how interesting that Europeans call nurses sisters—surely implying more care than cure.

As the caring branches of medicine were gradually pushed aside by the curing ones, there seemed to be less and less use for the Judeo-Christian virtues. I think that shortly the need for those old virtues will return and once again be at a premium. Our patients will need a helping hand and not a helping knife. This is no time to dismantle the low technology care model of medicine; it is a time to build it up, for the demographic data clearly tell us that whether we like it or not we shall be, in Shakespeare’s words:

> Into the lean and slippered pantaloon, with spectacles on nose and pouch on side; his youthful hose well sav’d, a world too wide for his shrunk shank, and his big manly voice, turning again toward childish treble, pipes and whistles in his sound. Last scene of all, that ends this strange eventful history, is second childishness and mere oblivion sans teeth, sans eyes, sans taste,—sans everything.

At that point we must either re-capture the old Judeo-Christian virtues of care or we shall be screaming to be induced into death to reach the “discomfort-free society.” Our problems are increasingly ethical and less and less technical. I would simply ask that when we use words such as medicine, health, disease, etc., we ask ourselves what we mean by them. For the key underlying bioethical question is: “To what purpose shall we do biology?”

Sargent Shriver

Knowledge for Service

Andre Hellegers is the only person I know of, male or female, clerical or lay, scholar or journalist, who predicted that Cardinal Wojtila of Cracow, Poland, would be elected Pope, the Bishop of Rome. He guessed right, I believe, because Hellegers possessed an uncanny sense of what the world needs at this moment in human history. Like the experienced medical clinician he was, Hellegers diagnosed what’s causing mankind’s current sickness and he recognized the perfect doctor for the times.

That “doctor” was not only a Bishop and Cardinal, a man of faith, a man of piety, and of pastoral warmth, but an ethicist, a casuist and philosopher who knew, theoretically and from his own experience as a worker, that Marxist-Leninism and consumer capitalism at best can fulfill only man’s material needs. Neither system even purports to deal with the spiritual aspects of human nature. One defines man only in materialist terms, the other wisely refrains from any pretensions in matters of the spirit.

Hellegers, like Pope John Paul II, saw that both these systems fall short in their attempts to reach and satisfy all aspects of human nature. The gap
between what they promise and what they can provide creates a vacuum which could be partially filled, Hellegers thought, by a new emphasis in education, in science and technology, in medicine, in law, in public and private life—a new emphasis on moral reasoning, on ethics, on values. That’s why he rejoiced in the creation of The Kennedy Institute of Ethics.

That’s why he devoted himself to public and private efforts to increase the rights of men and women, poor and rich, gifted and mentally retarded. That’s why he deserted the laboratory to join the struggle for equity in health care, in employment, in education, in religion itself.

As a public person he was indefatigable in meeting demands on his time: for testimony before Congress; for testimony as an expert witness in courts where he strove, successfully in the end, for the job rights of pregnant airline stewardesses; for lectures on bioethics to university audiences everywhere; for articles in newspapers, scholarly journals, and medical publications. Single-handed he brought into existence Georgetown’s respected Center of Population Studies and Demography, and with Dr. Paul Bruns he sought to make Georgetown’s Medical School pre-eminent in reproductive and developmental biology.

No one ever questioned his integrity or his intelligence. He put both into the service of his fellowman, into science, into the needs of mothers, fetuses, and babies, and into his own family life where his success with his wife and children is attested by their own achievements, their steadiness under pressure, their courtesy, their dignity, their ideals.

Hellegers displayed almost a priest-like patience and understanding even in debate. His was a gentle spirit combined with rigor to the intellectual disciplines: learning, accuracy, logic, thoughtful analysis, truth-telling.

His personal family has suffered much by his loss, but an even greater loss has been visited upon the larger family of man.

The principal character in William Styron’s new novel is Sophie, a young Polish woman. Imprisoned in Auschwitz-Birkenau, branded and enslaved, Sophie’s physical degradation and psychological disintegration finally evoke the cry—

. . . “God help me I don’t know what I am” . . .

Andre Hellegers tried to help people realize what they are. That’s what Pope John Paul II is striving to do. That’s what the Kennedy Institute of Ethics is striving to do. No wonder Hellegers sensed the Pope; no wonder he strove to focus The Kennedy Institute on the problems of man; no wonder he saw the question of our day as being not “who am I?” but “what am I?” No wonder Andre Hellegers will be missed.

Rev. Timothy Healy, S.J.

The Renaissance Man

Reverend Fathers, members of the Hellegers family, colleagues, friends and all who come to share this moment with Georgetown.

We gather at this Mass to face the mystery of death; a death unexpected and too soon, a death which to our eyes of time seems useless and unintelligible. There is a process to our knowing of death. First comes the tortured “no” of denial. Then, come pain and the stretching of the nerves. Last, if we are lucky, the therapy of tears, no less a healing, nor no more, than laughter.

Our next reaction is a gathering of forces, of persons, even of things. We seek distraction, the loss of hurt in busyness. In the midst of death we reach for life. We reach as humans and as Christians. We reach in the deepest and most frightening act of our faith. And the reaching is existential. So sharp and hurtful is our need, that reasons, justifications are unimportant. Faith in turn delivers its counter-shock. We say to ourselves, “if Christ be not risen . . .”, but we mean Andre; we mean ourselves.
Let us admit too that we mourn mostly for ourselves. We mourn the lost future, and in our dance of sorrow we forget the still point of Andre's eternal now. We mourn the lost promise, the undone work, forgetting that it is only to us in our bind of time that Andre's world of what might have been, the world of his dreams, is unreal. We mourn the lost friend, crying out in our loneliness as he did in his, for the Love which is now his fully and is not yet ours. We who toil at faith and hope mourn for him who no longer needs either, for he is now discovering with awe and wonder where Love has made his mansion. We have of course our human busyness as always. Last week we put to earth the last symbol Andre would have wanted us to confuse with himself. He lies where he loved, where gray stone and gray skies became part of the steel of his soul.

For all our grief, we know that not all added time means growth. If Andre's dreams were unfulfilled, they had never yet failed him. If the work he started was not finished, no piece of it was ill done. There was never really time for love to die, nor for honor to fade or wear out. We can even take joy in the fact that up to the night of his death, Andre worked, at a pace that few could equal, in the bright day. He never gave a thought to the dark. If we can and should, as men, rage at dying, at how quick bright things come to confusion, yet we must own in all simplicity that he is at peace and we are not.

Part of that peace was of course made long years before it came to dying. Andre was superbly alive in the best way that men are alive, in his knowledge and in his love. Both knowledge and love were for him bathed in the power and the beauty of the Incarnation. As today's Gospel insists, Jesus has made God known to us in a fresh way, in an incomparably new and seizable fashion. Here the Christian framework in which Andre grew and lived, served him well.

He had a ceaseless thrust in his mind to know, to understand, and to probe. He wanted facts. He wanted piles of them, bales of them, computer print-outs of them, but above and beyond the facts he wanted meanings. He was incredibly knowledgeable in so many areas, insatiably in search of knowledge, and the harder the fact the more he liked it. His own professional preoccupation with fetal physiology ("my little patients"), his knowledge and understanding of the workings of law, of foundations, of government, and above all his thirst for knowledge about the way man disposed himself across the face of the earth, all of this was endless, unsatisfied, and may even now be a strain on the recording angels. Even his rest was laborious. He told me he planned to use a sabbatical for a book on Catholic universities.

But never was this knowledge severed from his love. St. Thomas Aquinas has a haunting passage in which he says: "There are two ways of desiring knowledge. One way is to desire it as a perfection of oneself and that is the way philosophers desire it."

Obviously Andre fulfilled that definition, over and over again, in every published paper, in every lecture, I'm almost tempted to say in every letter to the editor. But Aquinas goes deeper. "The other way of desiring knowledge is to desire it not merely as a perfection of oneself but because through this knowledge the one I love becomes present to me, and that is the way saints desire it." It was this kind of knowledge that marked Andre Hellegers. He sought knowledge for itself, for the brisk edge it brought to his mind, for the clarity it offered policy, yes, all this indeed. But his was knowledge for service, knowledge that looked to draw the City of Man as close as possible to the City of God, knowledge that looked to the service of his creator and redeemer, loving knowledge that brought Andre for all his brilliance to a state of "complete simplicity, costing not less than everything".

His work of course will go on as he would have wanted it to, poorer for his absence, but surer and richer and more powerful for the years he gave it. This University in its immemorial ways will gather its strength about it and continue on, as it will do after the death of each one of us. And that too is the way Andre with a grin would have wanted it. Georgetown is Catholic, not only because it understands knowledge for itself as well as knowledge for love, but also because it can pass from the bright
rational day to the menacing dark and still know itself and trust its learning.

I said before we mourn principally for ourselves, because what we will lack is not the thrust of his work, or the ground of his calling. What we will lack is the man himself. The intelligence, the bright driving edge his mind, the slight burr of Holland in the voice, the wit that could convulse a table, and the insight that could cause each of us to gasp in recognition.

We who revelled in his power, who laughed and cared and struggled to understand as he did, who trod with him the large and heady highlands of great ideas, we can now walk only one path with him, the path of prayer. With him we echo “the Christian plummet sounding heaven and earth”; with him we feel “God’s breath in man returning to his birth”. So let us pray, an ancient aching act of faith.

“\textit{The Lord has given}” and we have known a good man who served God in his time, wittily, in the tangle of his mind:

“\textit{the Lord has taken away}”

I we who made so many words with Andre can see him grin at our lack of them now.

“\textit{The Lord has given, the Lord has taken away, blessed be the name of the Lord}”.

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**Dr. Paul Bruns**

**The Man Andre**

In Andre’s words, “... I have had occasion to reflect that given ten lifetimes of caring for pregnant women and delivering their babies... I could not possibly have done as much for women and children as was done through the establishment of the Kennedy Institute at Georgetown University. It’s a cheerful thought.”

Andre E. Hellegers, M.D.
Director, Kennedy Institute
Quarterly Report 1, 1, 1975

Georgetown University lost one of its most prized assets. Dr. Andre E. Hellegers died May 8, 1979 in Uithoorn, the Netherlands, of a heart attack. He is survived by his widow, Charlotte Lindsay Hellegers, R.N. and music graduate, one son Paul, age 21, named in honor of Andre’s brother who was killed in the R.A.F.’s battle of Britain, and three daughters, Caroline Ann, Desiree Eugenie and Renee Elizabeth. Dr. Hellegers had flown to the Low Lands to give several addresses on health care and its possible future. As was his custom he took one of his children with him on his European trips. On this occasion it was his 17 year old daughter Desiree Eugenie. Some of his “Reflections” on health care were given at a formal conference in Brussels, another at the 150th anniversary of the University of Tilburg Hospital in Tilburg, and on the evening of his death he talked informally at a dinner with his Limburgian friends in Laren.

Dr. Hellegers was born in Venlo, The Netherlands, June 5, 1926, the youngest of five sons. His mother had been a nurse and his grandfather and great grandfather were surgeons. His father was Director of a bank in Holland that was quite successful until Hitler’s rise to power. In 1932, at the age of 6, Andre decided to become a doctor. Personally, I think that his mother, a nurse, told him to become a doctor. I base this on the fact that when Andre finished his residency training in Obstetrics and Gynecology at Hopkins he was never again found in the operating or delivery rooms. Actually, I believe he really wanted to be a lawyer. At least, he told me that he recommended law school to his son Paul when he finished his studies at Oxford.

In 1939, the entire Hellegers family escaped the Nazi hordes by boarding a crowded boat to England. There, Andre, an expatriot, first learned English in a London suburb. His avid ability to pick up the cockney accent led his parents to enroll him in 1940, at age 14, in Stonyhurst College. This spartan Jesuit school, just outside of Manchester, had a profound influence on his intellectual, emotional and spiritual development, so much so, that he lies buried there in a simple pine box beside the gray stone chapel.

In 1944, at age 18, Andre entered medical school in Edinburgh. There he expanded his horizons of medicine
to include not only “cure” but also disease prevention, mental health and social well-being. Although he could appreciate the World Health Organization’s definition of health as “not the mere absence of disease, but total physical, mental and social well being” he had his doubts that the medical profession could provide infinite life and happiness here on earth with finite resources.

In 1953, at age 27, Dr. Hellegers emmigrated to the United States and joined Dr. Nicholson J. Eastman’s Department of Obstetrics and Gynecology at Hopkins. In his early years of training he translated numerous foreign scientific articles for Dr. Eastman’s “Comments” in the Obstetrical and Gynecological Survey. In his later years of research and teaching, he operated upon many sheep, goats and monkeys, sometimes at Yale with Dr. Barron, at others in the Andes, the Rockies, the Caribbean, and, oftentimes, in Washington and Baltimore. I soon learned that the brain Andre had the most respect for, was that of the Macaca Mulatta. He knew instinctively that if his elbow wandered close to the head end of the operating table, it would be clamped down hard upon. He needed no Papal Commission to advise him on matters of stark reality.

I first met Andre in 1957 while on sabbatical leave from Colorado. I learned the wide range of his scientific and classical knowledge while he hovered over the Scholander apparatus, chain smoking cigarettes of a strong imported variety. He did his thinking in French, his mathematics in Dutch, and he spoke and wrote in five languages. To say that in the laboratory, he suffered fools gladly is an understatement. This “Holland Connection” suffered, but with complete aplomb.

"He did his thinking in French, his mathematics in Dutch, and he spoke and wrote in five languages."

In 1963, Dr. Hellegers was appointed Senior Research Scholar of the Joseph P. Kennedy Jr. Memorial Foundation, and in 1964, while still at Johns Hopkins, he was made Deputy Secretary General of the Papal Commission on Population and Birth Control. Following several meetings at Dallas and Shrub Oak, New York, with clergy and obstetricians of international reputation, Dr. Hellegers developed his broad concept of biomedical ethics and outlined an interdisciplinary approach to the ethical, social, demographic, economic, theological, philosophical and political implications of medicine. His dream was to establish a center for scholars in each of these disciplines at a Catholic University. As Andre came to phrase it, “...the word Catholic can be spelt with either a capital or small C. The capital C is associated with Rome, the small c with Athens...If anything emerged from the 2nd Vatican Council, it is surely that you will make little sense of the Catholic unless you understand the catholic. Someday that may be understood in all places which call themselves universities.”

In 1968, Dr. Andre Hellegers was appointed Professor of Obstetrics, Gynecology, Physiology and Biophysics at Georgetown University. His journey from Carroll House in Baltimore to Georgetown University in Washington had now been completed. In 1971, while still continuing an extensive program of research, he created and became Director of a most unique institute for research, the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics. Thus Georgetown united the Renaissance-like University with the Renaissance Man.

In Andre’s words the Kennedy Institute is a haven for scholars. Only one criteria for admission was acceptable and that was professional competence. Scholars were of any and all denominations, and of none. They embraced Episcopalian, Jewish, Lutheran, Mennonite, Methodist, Presbyterian, Quaker and Roman Catholic and others. The purpose of the Institute was to assess man as a biological being, social being and—in an act of
faith and hope—as a transcendental being. "If you believe as I do that eternal life is more a product of the clergy to be attained in the hereafter than as functions of physicians to be granted in the here and now, you had better consider how you would like to pass from the here and now to the hereafter—and what it will cost in money and suffering."

Within the Kennedy Institute, Andre established several Centers. One of the first was the Center for Bioethics begun eight years ago under the directorship of Leroy Walters, Ph.D. The Bibliography of Bioethics, edited by Dr. Walters, and the Encyclopedia of Bioethics, edited by Dr. Warren Reich are two major products of the Center. Another is the Bioethics Library. These accomplishments reflect Andre's concept that the first need in any University is for brains and books rather than buildings.

Conrad Taeuber, Ph.D. joined the Institute early on as the Director of the Center for Population Research. Andre's reason for including demographers in an Institute with a primary focus in ethics was deceptively simple. As both Conrad and I recall, Andre repeatedly made the point that, 'one should know who they are, what age they are, and what changes might occur in their lives. The trick is to ask demographers the right questions.'

In spite of his love of facts and argument, he possessed, as Sargent Shriver said, an uncanny sense of what the world most needs at this moment in history. Andre had asked the right question of our day as being not, "Who am I?", but as, "What am I?". Shortly before his death he had applied for a sabbatical leave to prepare a volume of Essays in Bioethics plus a book tentatively titled "Prudence in Procreation". This was to be a book addressed primarily to teenagers.

Those who have read this far know that the person who should be writing this memorial is Andre himself. Were I to meet him for lunch at the 1789, as I frequently did, and were I to ask him to write his own memorial, he would likely say, as he always did, "No trouble, I'll dictate it tonight and have Carol (Ms. Carol Hetler, his secretary) send it to you after she types it." I am certain also that I would paraphrase it, remove all his favorite words, and palm it off as my own.

Rev. Richard A. McCormick, S.J.

He Was a Bridge Builder

It was more than fifteen years ago that I first met Dr. Andre Hellegers. That was the heyday of the discussions within the Catholic community on birth control. There were books by John Noonan, Louis Dupre, Daniel Callahan, studies by Louis Janssens, Robert Johann, George Shuster, Felix Cardegna and a host of others. Andre was already deeply involved in these discussions, not only for their own sake, but because he knew with his unerring second sense that this issue was inseparably woven together with the threads of many more important issues: authority in the Church, the place and function of the laity in the believing community, the theology of sexuality, the historical nature of moral knowing, the sanctity of life, etc. He also knew that a whole field of bioethics was out there waiting to be tilled.

In the area of bioethics, Andre Hellegers was not what one would call a scholar. He was a bridge-builder and communicator supreme. He brought different disciplines together to illumine and enlarge the frameworks of discussions. He profoundly respected the wisdom of classical value judgments, but he impishly loved to test accepted formulations of that wisdom, unsettling and infuriating less curious minds in the process.
I have never known anyone outside the field of ethics and moral theology who so quickly grasped the point of such an argument—and who so quickly saw its strengths and vulnerabilities.

While Andre loved a good argument, his own contributions to ethical discourse were almost invariably surprises, little twists and turns that others had not thought of, little medical or demographic glosses that would force one to hone or even recast the shape of one's analysis. For instance, in the long battle to gain pregnancy benefits for flight attendants—a struggle in which he played a key role—he tinkered with the notions of health and disease to the amusement, frustration and eventual illumination of congressional committees. To those who argued that pregnancy was a “disease” and therefore should enjoy medical benefits, Andre delightedly pointed out that he found it difficult to see how the human race survived through a disease. “Pregnancy benefits, yes. But let’s get the argument straight.” He playfully suggested that he had always dreamed of putting wrinkles into faces rather than taking them out—but for a society that revered the sapiential features of old age.

In 1974 Andre was approached by His Excellency Bishop Jerome Hamer, O.P., secretary of the Sacred Congregation for the Doctrine of the Faith. He was asked to give the Congregation some idea of what problems in bioethics would occupy our attention in the years to come. Many of us would have answered this request with a three or four page letter pro forma. Not so Andre. Laboring long hours for many months he composed a tome covering, in detailed chapter-fashion, the following: the environment of modern medicine; the notions of extensity and perpetuity; the issue of consent; the issue of abortion and definitions of life; the issue of euthanasia; the issue of genetics; the issue of transplantation; the issue of population; the notion of probabilism; the issue of communication and information; problems of research and teaching; the issue of privacy, etc.

“To be Catholic,” he argued, “one must first be catholic.”

This monumental effort remains the best indicator of how Hellegers conceived bioethical problems. He went to such precise lengths not to impress the Holy See with himself or his beloved Kennedy Institute of Ethics. He did so because he was convinced that ethical discussions must be firmly rooted in empirical data and approached with an open mind even if such data provided no value judgments. Furthermore he knew the potential influence of a great historical religious community (the Catholic Church) in this area and he sensed that its greatest obstacle to exercising this influence would be ideology, the imposition of supposedly invariable injunctions on a world that had changed or was changing.

Hellegers conceived the Kennedy Institute in the mid-sixties. He got the Center for Bioethics off the ground in the fall of 1971 with four theological ethicists (LeRoy Walters, Warren Reich, Charles Curran and myself) as a secretary. It was a shoestring operation with a single rule: be happy. But that easy informality—which we still enjoy and treasure—was cunningly conceived to maximize the potential of devoted scholars, and above all, to provide the genial atmosphere where the truly catholic could be discovered. Hellegers was convinced from the beginning that only an ecumenical process would retain an accurate focus on the humanum.

His own contributions to our deliberations and gropings at the Institute increasingly centered on the “soft issues” in bioethics, probably because he approached these questions through the filter of the notions of health and disease. For instance, he was far less concerned with the knockdown arguments about rightful wrongfulness of in vitro fertilization with embryo transfer than he was with its cultural assumptions and its impact on parenting and lineage. In this vein he feared above all the consumership mentality introduced into childbearing, the baby as
product: “Give me blue eyes this time, doctor.” He felt that the sense of awe, of tragedy at loss, of delight at surprise was silently slipping away in such attitudes.

Somewhat similarly, when he thought of the moral problems associated with care of the dying—for instance, the Quinlan case and the California Natural Death Act—he saw health-disease assumptions at work. Thus he was deeply concerned that the actions-reactions in the Quinlan case tended to reinforce the noxious notion that physicians are masters of their patients and not their servants and that we must have recourse to the courts to subtruct ourselves from the jurisdiction of physicians. He was so concerned with this issue because the tendency to lessen patients’ rights would blunt those healthy, human and religious perspectives that are intended to inform the exercise of those rights. Thus he repeatedly insisted that the accumulation of minutes of life is not the moral guideline by which dying ought to be done. In the last paper he authored (for Loyola University of Chicago, where he received posthumously an honorary doctor’s degree) he stated of medicine that “increasingly our new task shall be to add life to years, and not years to life.”

In the proliferation of modern technology, Andre felt an intensified need for the Christian virtues. As he notes in the paper published here, “this is no time to dismantle the low-technology care model of medicine; it is a time to build it up... our problems are increasingly ethical and less and less technical.” In our time, he argued, patients need a helping hand, not necessarily or always a helping knife.

“In our time, he argued, patients need a helping hand, not necessarily or always a helping knife.”

That is vintage Andre Hellegers, a subtle and witty mind constantly afflicting the comfortable. He made it difficult for anyone to stand intellectually still—and he made it a delightful experience to move ahead with him. As a bioethician, he was a renaissance man in a technologized culture. All of us at the Kennedy Institute experienced that as a breath of fresh air.

Dr. Conrad Taeuber

Asking the Right Questions

Andre Hellegers once wrote that he had long held the view that “demographers are an extraordinarily useful lot.” Although he often encountered people who confused demographers with activists seeking to control rates of population growth, he saw demographers as pro-people, “whether in birth, in death, in movement or in that generic term, ‘the economy’.” For him the reason for including demographers in an Institute with a primary focus in ethics was deceptively simple. “Ethical problems concern people. One should know who they are, what age they are, and what changes might occur in their lives.” In his opinion, demographic facts were essential to sound health planning, realistic ethical analyses, and related activities. As he put it on one occasion: “The trick is to ask them [the demographers] the right question.”

He asked the right questions in the case of a lecture he had prepared to deliver at Loyola University, but did not live to present, reproduced in this issue of the Quarterly Report. It illustrates how well he was able to bind together demography and bioethics.
He started with the demographic facts of gradually increasing expectation of life and the expected large increase in the number of persons past retirement age. These facts led to questioning whether the medical establishment is really ready for the tasks of the future. In many discussions with Andre we explored the traditional approaches to health services which are being challenged, in part because of the rapid growth in the number of people past retirement age with their special health problems.

“The trick is to ask them [the demographers] the right question.”

For Andre, pervasive institutionalization of the elderly was not a viable policy option; alternatives must be found. Similarly, the care of the handicapped called for new insights and for new approaches to the integration of these individuals into the community and the economy. Here too he served as an interpreter of demographic facts. Cognizant of the needs for action programs, he nevertheless demanded the hard facts which outlined the problems and thrusts. Andre lost no time in taking the first step—finding the money needed to acquire the computer tapes and to extract new information. With this program now underway at the Institute, another means has been identified to merge the analysis of acts into ethical and policy-making considerations.

A mathematical model of human reproductive behavior became something more than an academic toy when Andre saw that it could be used to estimate the very real social consequences of changing age at marriage, changing patterns of child-bearing and child-spacing, and the reduction of infant mortality. General and professional audiences delighted in listening to Andre’s clear explanation in lay terms of such complicated models. He made it possible for many to understand the importance of demographic estimates in advance, to provide realistic means of measuring program effectiveness later, and avoiding potential disappointment when it turned out that unrealistic expectations were not and could not be met even though a program had been in effect for years.

Persons with handicaps were of special concern to Andre, whether they were infants requiring care, adults lacking certain mental, emotional or physical characteristics, or older people facing the decline of abilities or skills they had possessed earlier in life.

Before venturing to evaluate any policy or to assess any ethical position, Andre always wanted to ascertain the underlying facts. For instance, in the mid-1960’s, Andre and Dr. Murray Gendell investigated to what extent a decline in infant mortality rates in a major city reflected newer and improved medical services to infants, or whether it was only a change in the age at which mothers were having their babies. By asking the right question, this investigation of the facts led to surprises regarding the true causes in a decline in infant mortality rates, and produced a change in the explanatory model describing program effectiveness.

“Cognizant of the needs for action programs, he nevertheless demanded the hard facts which outlined the problems.”
With increases in the labor force participation of women, questions began to be raised concerning the treatment of pregnant women at work. Inevitably Andre was drawn into discussions of the issues raised. Again, Andre's first action was to call for the facts. How many women were involved? What types of jobs were affected? What did medical research say on the potential effects on mother and child? Armed with the facts, he argued effectively in the courtrooms, taking the position that unnecessary restrictions on healthy pregnant working women should be legally banned in the early months of pregnancy.

"No one ever asks the questions this way." That, for him, was the challenge on many occasions. In one discussion with persons active in health policy, the question was raised whether health costs would be decreased if cancer were eliminated. Commenting on that discussion, Andre reported that, "Having been asked to be a respondent and being by nature heretical, I questioned the approach on the grounds that in making the choice, one was merely trading off forms of dying. My comments were considered quaint then as they are now." He felt that research addressed to a major killer, such as cancer, should take into consideration the basic facts about other killers, and the effects on mortality rates should one of them be conquered. In the absence of physical immortality, the society could in effect choose how to pass from the here and now, and could choose what it would cost in money and suffering. Could the demographers supply facts which would assist in dealing with these questions? They did, and the results were surprising to people, primarily because the question had not been asked this way before.

"Ethical problems concern people."

Andre's mind was not fettered by the subject categories of the academic world, nor was it fettered by geography. For him, problems of food and population were world-wide and were to be treated on that basis. Population trends were an essential ingredient in the economic development of the third world and detailed analyses of the interrelationships were needed to understand what was going on there and as a basis for guiding policy.

Since the Center for Population Research (CPR) first became an integral part of the Institute in 1971, the role of demographic research within the Kennedy Institute has changed. Andre's visits to the Center and his calls for a wide variety of data reflected the growing range of concerns of the Institute. At the same time, he saw the possibilities of outreach into the larger community, as through the teaching function which sent graduates out into government, inter-
national, research, academic and action organizations where they could put to work the skills and insights they had gained during their stay at the Center. Andre encouraged the establishment of cooperative arrangements with training centers in some of the developing countries, and this continues to be high on the agenda of unfinished tasks.

Policy considerations might identify problems for research, but they could never control the direction and conclusions of such research. Research findings might lead different persons to draw different policy conclusions. For Andre Hellegers the two lines of activity were essential though distinct. Both continue to play a fundamental role in the Institute, even in his absence.
Pat Schifferli

A Community of Responsible Adults

We called him “Fearless Leader”. The name was not derogatory, but an affectionate and slightly awed recognition of the quality of the man. He dealt with difficult situations, sometimes involving powerful people, with grace and wit and good common sense that charmed, coaxed, goaded or coerced others to take the course of action that he deemed the best.

His judgement was seldom wrong. He knew how any act of his as director would affect all the constituencies with which he was concerned. He maintained this awareness of present allies even though he was always interested in expanding, always looking for new projects that might sprout out of the old.

From the point of view of organization, he wanted the Kennedy Institute to be a “community of responsible adults”. He kept a benevolent distance from his staff, expecting and allowing them to perform their tasks without any intervention from him. Yet he always gave support when it was needed—a quick decision, a recommendation, a placating phone call. He was intensely loyal, going to great lengths to shield his people from criticism, yet he never showed that he expected anything in return. He is sadly missed.