Managing Abnormal Pregnancies Prior to Viability

During Holy Week, a reporter from the W*ashington Post* contacted CHA to inquire why Catholic hospitals do not perform D&Cs. He claimed to have received a call from a woman who said she had been refused such at a Catholic hospital in the Northeast. During the course of a conversation with Sr. Carol Keehan, the reporter made mention of an article that seemed to support the woman's claim. He later emailed the article to CHA.

The article in question ("When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals," by Lori R. Freedman, Ph.D., Uta Landy, Ph.D., and Jody Steinauer, MD, MAS) appeared in the October 2008 issue of the *American Journal of Public Health* (Vol. 98, no. 10, pp. 1774-78). It has since been cited in a more recent article in the same journal and is summarized in the *NEJM's Journal Watch* (14, no. 1, January 2009: 5).

The authors interviewed six OB-GYNs "working with and within Catholic-owned health institutions, each of whom reported at least one … event" (1776) in which the physicians were barred "from completing emergency uterine evacuation while fetal heart tones were present, even when medically indicated" (1777). The physicians claimed that in these cases, "Catholic doctrine interfered with their medical judgment" (1774). Based on these six interviews, the authors convey the impression that miscarriage management is deficient in Catholic owned-hospitals because of the institution's moral beliefs and its "right to refuse care as granted by 'conscience clauses'" (1778).

The authors make several misleading claims in the article. Among the more concerning are the following:

- Catholic hospitals (i.e., ethics committees) do not permit uterine evacuation so long as fetal heart sounds are present. This seems to be the chief complaint.

- "Contradictory interpretations of Directive 47 in the Catholic health literature and in practice indicate that ethics committees are either uncertain or in disagreement about how to manage miscarriage when fetal heart tones are present and what exact circumstances allow for termination of pregnancy in Catholic-owned hospitals" (1778).

Regarding the first claim, Directive 47 is the operative Directive when the fetus has not reached viability. The Directive 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*" (emphasis added). Nothing is said here about having to wait until there are no "fetal heart tones" before intervening. Nor does any other authoritative source require this. In fact, Directive 47 makes no sense if clinicians must wait until the cessation of a fetal heartbeat. The very point of the Directive is to allow for an *indirect abortion*. It recognizes that medical interventions to address a serious pathological condition of a pregnant woman might indirectly cause the death of the fetus. Directive 47 does not require that the fetus already be dead before intervening. Where this assumption comes from is not clear, but it is not from Church teaching and it should not be from ethics committees or ethics consultants in Catholic hospitals.

The article in question refers to "the manual used by Catholic-owned hospital ethics committees to interpret the directives …" (1775). One could easily get the impression that it is this manual that prohibits any medical intervention if there are fetal heart tones. The manual that is being referred to is the one published by the National Catholic Bioethics Center (NCBC): *Catholic Health Care Ethics: A Manual for Ethics Committees*, edited by Peter Cataldo, Ph.D. and Albert Moraczewski, O.P., Ph.D. However, neither in the NCBC's statement on their website on early induction of labor nor in the article on "abnormal pregnancies" in the manual

(Chapter 10A, "Medical and Ethical Considerations Regarding Early Induction of Labor") is there any mention of not intervening so long as there is a fetal heartbeat.

The website statement reads: "Early induction of labor for chorioamnionitis, preeclampsia, and H.E.L.P. syndrome, for example, can be morally licit under the conditions just described because it directly cures a pathology by evacuating the infected membranes in the case of chorioamnionitis, or the diseased placenta in the other cases, and cannot be safely postponed" (www.ncbcenter.org/04-03-11-EarlyInduction.asp). As the statement suggests, this position rests on the principle of double effect which is explained as follows:

> Actions that might result in the death of a child are morally permitted only if all of the following conditions are met: (1) treatment is directly therapeutic in response to a serious pathology of the mother or child; (2) the good effect of curing the disease is intended and the bad effect foreseen but unintended; (3) the death of the child is not the means by which the good effect is achieved; and (4) the good of curing the disease is proportionate to the risk of the bad effect (ibid.).

The article in the manual reiterates the substance of this position and, again, there is no mention of fetal heart sounds. Ethics committees and ethics consultants should not be confused about this if, in fact, there is confusion.

The emotional difficulty for clinicians, however, when there are fetal heart tones, should not be minimized. There is anecdotal evidence to suggest considerable reluctance on the part of clinicians to intervene when the fetus is still alive. Such reluctance is certainly understandable. In fact, one would have reason to be concerned were it not present. But the emotional reaction to these difficult situations and decisions (i.e., the reluctance to intervene when fetal heart tones are present) is not the same as the Church's teaching. The authors of the article got it wrong. And it is quite likely that a good number of the ethics consults in response to abnormal pregnancies result from a tension between what the Church (and Directive 47) permits and the sensibilities of clinicians.

The article makes another point, namely, that "uterine evacuation may not be approved during miscarriage by the hospital ethics committee if … the pregnant woman is not yet ill, in effect delaying care until … the pregnant woman becomes ill, or the patient is transported to a non-Catholic owned facility" (1775), and quotes the ethics committee manual's explanation: "The mere rupture of membranes, without infection, is not serious enough to sanction interventions that will lead to the death of the child" (1775). The manual goes on to say the following:

Chorioamnionitis endangers the life of the mother and therefore constitutes a "proportionately serious pathological condition." Hence, in Catholic facilities, preterm premature rupture of membranes calls for expectant management, unless or until chorioamnionitis supervenes. In this situation, there is virtually no chance of fetal survival and, because the mother's life is in danger, induction of labor may be morally justified under the conditions stated above in Directive 47 (10A/2).

This statement, which accurately reflects Church teaching, rests on the absence of condition 3 in the principle of double effect, i.e., that the death of the fetus cannot be a means by which the good effect is achieved. The absence of chorioamnionitis turns an indirect abortion into a direct abortion.

Unfortunately, the article contrasts the position enunciated in the NCCB's manual with an article that appeared in *Health Progress* (Jean deBlois and Kevin O'Rourke, "Care for the Beginning of Life: The *Revised Ethical and Religious Directives* Discuss Abortion, Contraception, and Assisted Reproduction," 76, no. 7 [September-October 1995]: 36-40), characterizing the former as "conservative" and the latter as "liberal." What the authors of the article seem to have missed in the deBlois/O'Rourke article is that the diagnosis in the case example is "'probable uterine infection and threatened abortion'" and they fail to understand the subsequent explanation for why the intervention in this case constitutes an indirect abortion.

In sum, the article in the *American Journal of Public Health* falsely characterizes the Church's teaching on dealing with abnormal pregnancies as well as the general practice in Catholic hospi-

tals. While there may be occasional misunderstandings in practice or some variability in the application of Directive 47 because of the complexity of clinical circumstances and the sensibilities of clinicians, the guidance offered by the Directives is quite clear:

- The goal of any medical intervention is to save the lives of both the mother and the fetus to the extent that this is possible.
- When this is not possible, the direct purpose of the intervention should be to save the life of the woman and **not** to terminate the life of the fetus. Hence, the intervention cannot be the direct cause of the death of the fetus. This would constitute a direct abortion which is never morally permissible. However, the intervention needed to address a serious pathological condition can be the indirect cause of fetal demise.
- The woman must have a proportionately serious pathological condition.
- The intervention that would indirectly lead to fetal demise should be a last resort.

— *R.H.*

For a very helpful article, see Edward R. Newton, MD, "Preterm Labor, Preterm Premature Rupture of Membranes, and Chorioamnionitis," *Clinics in Perinatology* 32 (2005): 571-600.