

Early Pregnancy Complications and the ERDs

Ron Hamel, Ph.D.
Senior Ethicist
Catholic Health Association
St. Louis
rhamel@chausa.org

Introduction

The last few months of 2013 and the very beginning of 2014 have seen several attacks on Catholic health care, more specifically, how Catholic health care addresses obstetrical complications. At the annual meeting of the American Society for Bioethics and Humanities in October 2013, Professor Lori Freedman from the University of California, San Francisco delivered a short paper that took Catholic health care to task. She subsequently published an article (together with Debra Stulberg, MD of the University of Chicago) in the October-December 2013 issue of the *American Journal of Bioethics* titled “Conflicts in Care of Obstetric Complications in Catholic Hospitals.”¹

On Dec. 2, 2013, *The New York Times* published an article, “Bishops Sued over Anti-Abortion Policies at Catholic Hospitals.”² The article reports the American Civil Liberties Union (ACLU) lawsuit against the United States Conference of Catholic Bishops (USCCB), claiming that the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) issued by the USCCB were responsible for “negligent care” of a pregnant woman with an

obstetric emergency being treated in a Michigan Catholic hospital. The article was followed on Dec. 8, 2013 by an editorial, signed by the entire editorial board, titled “When Bishops Direct Medical Care.”³

On Dec. 12, 2013, *The Washington Post* published an article, “Catholic Hospitals Are Growing. What Will That Mean for Reproductive Health?”⁴ The *Washington Post* article also cites an article by Deborah Stulberg, MD and three other colleagues that appeared in the July 2012 issue of the *American Journal of Obstetrics and Gynecology*—“Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies.”⁵ Stulberg’s article follows upon another (“Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care”) published in 2010 in the *Journal of General Internal Medicine*.⁶

A month before the *Washington Post* article, a Colorado newspaper reported that the ACLU had filed a complaint against Mercy Regional Medical Center in Durango, Colo. claiming that the hospital forbids physicians and other employees from discussing abortion with

patients, even if a pregnancy threatens a woman's life.⁷ On Dec. 18, 2013, the ACLU together with MergerWatch released a report titled, "Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care."⁸ Needless to say, newspapers, magazines and blogs across the country picked up this story as well as that of the ACLU lawsuit against the USCCB. Finally, on Jan. 1, 2014, the *New Republic* published an article by Prof. Freedman—"Bishops Run Catholic Hospitals—And Should Be Liable When Their Edicts Lead to Error: New Research into Medical Decisions at Church-Run Facilities."⁹

Freeman and Stulberg, along with the ACLU and MergerWatch, seem to have embarked on a vigorous campaign against Catholic health care in general and the practice of obstetrics and gynecology in Catholic hospitals in particular. Theirs, of course, are not the first such attacks. They are simply the most recent wave. Much could be written about the errors in their work, questionable methodologies, unfounded generalizations, biased selection of events, facts, and interpretations, as well as a general lack of understanding of Catholic health care and of what actually occurs in the vast majority of Catholic hospitals across the country. That, however, is not the purpose of this article.

What follows has a different purpose. It examines four areas relating to obstetrical complications in the hope of providing some greater clarity about the guidance provided by the *ERDs* and the Catholic

moral tradition. The situations that these and other authors describe are rarely the result of the *ERDs* themselves, though these tragic events have been attributed precisely to observance of the Directives. In some instances, there may have been a lack of knowledge about what specific Directives actually say, or a misunderstanding or misapplication of the certain Directives. But this is not the fault of those Directives that are relevant to early pregnancy complications. In other instances, the Directives simply made and make an easy target. The cause of these situations, assuming they occurred as described, may have had nothing to do with the Directives or with the hospital's being Catholic. The four areas to be considered are informed consent, ectopic pregnancy, miscarriage, and preterm premature rupture of membranes (PPROM). These are the primary issues that repeatedly surface in challenges to Catholic health care's dealing with obstetric complications.

Grounding Convictions and Principles

A Catholic approach to obstetric complications is shaped by several fundamental beliefs and ethical principles. The first of these is respect for the dignity of all human beings. This entails seeking the well-being and flourishing of all, including nascent human life, and doing nothing that would violate the inherent value of all human life. In this regard, the Directives state that "[T]he Church's commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning" and that the "Catholic health ministry witnesses to the

sanctity of life ‘from the moment of conception until death.’ The Church’s defense of life encompasses the unborn and the care of women and their children during and after pregnancy.”¹⁰ An immediate consequence of this fundamental conviction is that in cases of obstetrical complications, Catholic hospitals will attempt to save both lives when that is possible. In the vast majority of cases, this is exactly what the mother/parents want. They want to try to save the pregnancy, to have this child, and they want to do whatever is feasible to try to make that happen.

A second consequence of this grounding belief is the moral principle that prohibits the directly intended ending of a pregnancy before viability or the directly intended destruction of a viable fetus. Either would constitute a direct abortion. Directive 45 addresses this. But this is not the last word. Some procedures do not directly intend the termination of a pregnancy and do not have as their sole immediate effect the ending of a pregnancy. Such procedures are considered to be indirect abortions and can be morally permissible. They are justified on the basis of the principle of double effect, another of the ethical principles that shapes how obstetric complications are handled in a Catholic facility.

Briefly, the principle of double effect applies when an action has at least two simultaneous effects—one good and intended and the other bad and foreseen but not intended. The principle has four conditions, all of which must be present

for an action to be considered “indirect” and, thus, morally acceptable. The first is that the act in question (or the procedure) must be “good” or “neutral” in its moral quality. Second, what is intended is the good effect and not the bad. Third, the good and bad effects must occur simultaneously, thus avoiding a situation where the bad effect becomes a means for achieving the good effect. Morally speaking, in the Catholic tradition and elsewhere, one ought not use a bad means to achieve a good end. Finally, there ought to be a proportionate reason, that is, there ought to be a sufficiently serious reason to permit the bad effect. This principle gives rise to several Directives that provide guidance when dealing with particular obstetrical complications, as will be seen below. First, however, we turn to an issue that is not an obstetrical complication, but that is foundational to all decision-making—informed consent.

Informed Consent

One of the charges made against both the Muskegon and Durango hospitals is that the patients involved were not adequately informed about their condition and their choices. This failure is laid at the feet of the Directives. What do the Directives say about informed consent? Directive 26 states that “the free and informed consent of the person or the person’s surrogate is required for medical treatments and procedures . . .” Directive 27 is somewhat more specific. It reads: “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.” And, finally, Directive 28 states that “each person or the person’s surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person’s surrogate is to be followed so long as it does not contradict Catholic principles.”¹¹ What is to be made of what is said here?

First, it is important to keep in mind the distinction between a direct termination of pregnancy which is morally prohibited, and an indirect termination of pregnancy which is morally permissible when there is a sufficient reason. There should be no question about informing a woman of the possibility of a termination of her pregnancy that is *indirect* in those situations in which it is medically indicated or is a medically feasible option. Quite probably, indirect abortions would cover the vast majority of early pregnancy complications where a termination of pregnancy seems to be medically indicated to resolve the complication. However, what about a direct abortion? Can that be mentioned as part of the informed consent process? While some will disagree, full disclosure of *medically* appropriate or indicated options, *factually relevant information*, including direct abortion, in difficult obstetrical situations can and should occur, within certain parameters. What is the rationale for this and what are the parameters?

It is no mistake that Directives 26-28 come under Part Three of the ERD, which reflects on the nature of the patient-professional relationship. The individual Directives within Part Three discuss critical features of this relationship and outline some of the basic rights and responsibilities of patients and professionals alike. It is also no mistake that the Introduction to Part Three as well as Directive 23 reaffirm the notion of respect for human dignity which is seen as the foundation of the professional-patient relationship. Informed consent is an expression of respect for human dignity. To violate informed consent is to violate human dignity. Intimately related to human dignity and to informed consent is conscience as underscored in Directive 28.

Human beings ought to make decisions that are true to their consciences, to what they discern in their heart of hearts that God is calling them to be and do in the concrete. This is a difficult task that is made all the more difficult when they are not given complete information by those they trust to provide it. A basic moral responsibility of providers in Catholic health care organizations is to communicate *factually relevant information* to patients so they can properly inform their conscience. Directive 28, as already noted, describes this well: “Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience.” Receiving such factually relevant information, of course, is only one piece in the formation of an individual’s conscience. Much more is required.

Directive 28 is important for several reasons. First, it recognizes the primacy of conscience by stating that the patient should be given *medical* and moral information necessary to inform her or his conscience. In so doing, the Directive suggests that providers in Catholic health care facilities cannot usurp the moral authority of a patient to direct her or his own life according to her or his conscience by failing to disclose factually relevant information. Second, the Directive implicitly makes a crucial moral distinction between disclosing information and providing services that are not in keeping with Church teaching. It does this by indicating that providers in Catholic health care facilities need not honor all patient decisions, especially those that violate Catholic principles, but they must share factually relevant information with a patient so that she or he can inform her or his conscience. This moral distinction is indispensable if providers in Catholic health care facilities are going to fulfill their medical, moral, and legal responsibilities to patients, while at the same time preserve their identity and professional integrity in a morally pluralistic society as well as the faith-based identity of the organization. Thirdly, Directive 28 speaks to *moral* information. This is another essential component of the formation of conscience and ought not be overlooked in the clinical context. In fact, as will be seen below, disclosure of factually relevant information also provides an opportunity for providing the patient with moral considerations.

It is in the Introduction to Part Three that we find another compelling reason,

beyond that of informing conscience, why providers in Catholic hospitals have a moral responsibility to disclose fully all factually relevant information to the patient. In a word, that reason is *trust*. One of the building blocks of the patient-professional relationship, trust is essential if the patient is going to feel free to share personal information necessary for effective care as well as heed the expert advice of the professional when it comes to following the care plan. If physicians in Catholic hospitals were to routinely and systematically refrain from disclosing factually relevant information, to what extent would that weaken the trust patients have in them and the health care professionals that practice in Catholic facilities? This is not a rhetorical question. It is one that must be taken seriously. The ability of physicians to carry out their healing mission would be gravely undermined if the building block of trust were weakened or destroyed altogether. Of course, there are other reasons for full disclosure of factually relevant information—legal requirements associated with informed consent, avoidance of malpractice lawsuits and, above all, avoidance of serious harm to the pregnant woman.

Earlier, full disclosure of factually relevant information was qualified by “within certain parameters.” What are those parameters? While there are important moral reasons for providing patients with all factually relevant information, the *way* in which the information is imparted is a critical component of the disclosure process. When it comes to actually stating the prohibited option, providers in

Catholic health care organizations should do so in an objective, factual manner, neither approving nor recommending, pointing out that the procedure is not offered in the Catholic facility and explaining *why* this is the case. This is critical for full disclosure to be acceptable morally. It is critical for the patient's own moral education and the formation of his or her conscience, as well as for the integrity of the institution and the professional integrity of the provider. A number of Catholic health care facilities with obstetric departments, especially those that deal with high acuity patients, have a template of script to assist physicians or other clinicians in this communication.

Ectopic Pregnancy

As is generally well-known, an ectopic pregnancy involves the attachment of an embryo to something other than the endometrium, usually the wall of the fallopian tube. The resulting abnormal growth can result in rupture of the tube, severe hemorrhaging and even death for the mother. In developed countries, the death rate from ectopic pregnancies is approximately 9 to 13 percent, while in undeveloped countries, it is considerably higher. Treatment of ectopic pregnancy can take three forms—expectant management, surgical, and medical.

The first, *expectant management*, consists in simply monitoring the situation to see if the tubal pregnancy resolves on its own. Most women are not candidates for expectant management. *Surgical treatment* can take two forms. One consists in the

partial or complete removal of the fallopian tube, which also contains an embryo (salpingectomy). The other involves slitting the fallopian tube and “stopping the destructive activity of the trophoblast by removing the invasive trophoblastic cells along with the damaged tubal tissue.”¹² The embryo is also necessarily removed in the process (salpingostomy). The third form of treatment, *medical*, consists in the administration of the drug methotrexate which prevents the trophoblastic cells from continuing to divide and doing damage to the tube that could result in severe hemorrhaging. The embryo also eventually dies. The use of methotrexate increasingly seems to be the preferred treatment because it does not involve surgery and leaves the woman's fertility intact. Salpingostomy can also preserve the woman's fertility.

What do the ERDs say about ectopic pregnancies? Directive 48 speaks to this situation: “In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.” In light of Directive 48, the question is whether any of the procedures mentioned above constitutes a direct abortion. While the first approach results in the death of the embryo, the embryo's demise is not intended, nor is there any direct attack on the embryo. A pathological tube is removed that results in two effects—prevention of harm to the mother (the intended effect) and the demise of the embryo (the unintended effect). There is clearly a proportionate reason—the mother's well-being is preserved and the embryo, though it dies, actually has no

chance at survival. Virtually all theologians agree that salpingectomy constitutes an indirect abortion and so is morally licit. The demise of the embryo is foreseen, but not intended.

Among Catholic theologians and ethicists, there is disagreement regarding the third and fourth procedures. Some see them as a direct attack on the embryo and, so, a direct abortion,¹³ while others see them as aimed at removing pathological tissue—the trophoblast—which unavoidably results in the death of the embryo. They judge this to be an indirect abortion.¹⁴ For example, Ashley, deBlois and O'Rourke state: “[M]ethotrexate is often used to treat the pathology caused by the abnormal location of the fertilized ovum. While it would be wrong to detach a fertilized ovum from its normal site of implantation, to detach it from an abnormal site that constitutes a serious pathological condition in the woman’s body would seem to be licit. Hence, the direct intrinsic intention ... of the surgical or pharmaceutical act ... seems to be to protect the health of the mother, and the death of the conceptus is not intended. For this reason, it is our opinion that salpingostomy and the use of methotrexate do not result in direct abortion and therefore are in accord with Directive 48.”¹⁵ *The magisterium has not resolved this controversy.* Hence, neither Church teaching nor the ERDs forbid the third or fourth approaches (so long as these approaches can legitimately be argued as not constituting direct abortions). Currently, both opinions are in play.

If some Catholic hospitals have policies that prohibit salpingostomy and the use of methotrexate, this is not because these procedures are forbidden by Church teaching or by the ERDs. Rather, it is because an individual or individuals decided either to take the safer course or personally believed that salpingostomy and/or the use of methotrexate constitute direct abortions and are, therefore, in conflict with Directives 48 and 45. However, given the ongoing debate, it is permissible for Catholic hospitals to employ both salpingostomy and methotrexate. As the editors of the National Catholic Bioethics Center’s *Catholic Health Care Ethics: A Manual for Practitioners* note: “Resolution of the debate will depend on further specification of the exact nature of these medical procedures and further refinement of the arguments about the moral object of each act. Generally, if there are two competing but contrary bodies of theological opinion about a moral issue, each held by experts whose work is in accordance with the magisterium of the Church, and if there is no specific magisterial teaching on the issue that would resolve the matter, then the decision makers may licitly act on either opinion until such time that the magisterium has resolved the question.”¹⁶

Miscarriage

Another of the obstetric complications that the ERDs supposedly prevent from being adequately treated is miscarriage of which there are several types. A *missed miscarriage* occurs when there is a fetal demise (usually for a number of weeks),

but there is no uterine activity to expel the products of conception. A *complete miscarriage* occurs when all the products of conception have been expelled without the need for surgical or medical intervention. A *threatened miscarriage* occurs when any bleeding is seen during pregnancy prior to 20 weeks' gestation. Upon examination, it may be found that the fetus remains viable and the pregnancy continues without any further problems. Expectant management (i.e. bed rest) is the typical treatment. When there is vaginal bleeding with dilation of the cervix and the fetus has not yet been expelled an *inevitable miscarriage* exists. In these cases, bleeding can be severe and abdominal pain and cramping often occurs. This situation virtually always progresses to a complete miscarriage. There may or may not be a fetal heartbeat. An *incomplete miscarriage* occurs when there has been expulsion of some but not all of the products of conception before the 20th week of pregnancy. Parts of the fetus, placenta, or membranes might have been retained. Vaginal bleeding is heavier and abdominal pain is almost always present. The mouth of the womb is open and the pregnancy is being expelled. Some miscarriages can become septic, a *septic miscarriage*. Here, tissue from a missed or incomplete miscarriage becomes infected. This condition carries the risk of spreading (septicemia) and poses a grave risk to the life of the mother.¹⁷

The treatment options for miscarriage are three—expectant management or watchful waiting, surgical evacuation of the products of conception, and medical (chemical) evacuation. While surgical

intervention has been the conventional treatment for first trimester pregnancy loss and is the treatment of choice for unstable patients, non-surgical treatments have been increasingly introduced and appear to be effective and satisfactory for certain patients.¹⁸ With expectant management or watchful waiting 65-80 percent of miscarriages resolve within 2-6 weeks with no higher a complication rate than from a surgical intervention. Nor is there any difference in short term psychological outcomes. Medical management involves the use generally of misoprostol to prompt the completion of the miscarriage. It has been shown to be as effective as manual vacuum aspiration with complete evacuation rates of 95-99 percent after 1-2 weeks. Surgical treatment (dilation and curettage or vacuum aspiration) is the fastest way to complete the miscarriage. It shortens the duration and heaviness of bleeding and avoids the pain associated with miscarriage, but has its own complications. Some studies suggest that there is no indication for routine surgical management. Medically, surgical treatment is indicated when the woman has unstable vital signs, uncontrolled bleeding, or evidence of infection. Selection of treatment obviously depends on the clinical situation and the patient's judgment.

How might we think about these treatments from an ethical perspective? Two Directives are relevant here. Directive 45 states: "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.” And, the second, Directive 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.” Several things need to be noted and kept in mind regarding Directive 47. The *direct purpose* of the intervention is to save the life of the mother or protect her health and not to terminate the life of the fetus. Second, the woman must have a *proportionately serious pathological condition* and the intervention is a treatment/cure for that. Third, the intervention should be a *last resort* (i.e., waiting is not feasible and lesser means have not been or will not be effective). Fourth, the Directive recognizes that the intervention might *result in the death of the fetus*, hence, in some cases, the presence of fetal heart tones does not preclude an intervention.¹⁹

In light of the guidance provided by these Directives, which of the treatment options would seem to be morally acceptable for the various types of miscarriage? Obviously, in cases of a *complete miscarriage*, there is no question of treatment. In a *threatened miscarriage*, expectant management is the morally acceptable treatment because the fetus remains alive and the pregnancy may continue on to term. Medical/chemical and surgical treatment would not seem to meet the requirements of Directive 47 or the conditions necessary for an indirect

abortion. When an *inevitable miscarriage* is at issue, expectant management and medical therapy would both be morally acceptable. If expectant management is not feasible due to excessive bleeding and/or pain or other factors such as the clinical ability of the facility, the use of a pharmaceutical agent to induce labor is not a direct attack on the fetus, but rather a measure to evacuate the uterus in order to resolve a pathological condition. This would be considered an indirect abortion from a Catholic perspective. Surgical management in this situation is more ambiguous. On the one hand, it would seem to be a direct attack on the fetus. On the other hand, surgical management is aimed at evacuating all the products of conception from the uterus of which the fetus is one. In this sense, could it be considered indirect? In the case of an *incomplete miscarriage*, because the fetus is already dead, any of the forms of treatment would be morally permissible. The primary concern here should be the well-being of the mother. The same would be true of a *septic miscarriage*. Of course, whenever the fetus is already deceased, the method of evacuation of the uterus can be determined solely on medical considerations and the judgment of the mother. Any of the methods would be morally permissible.

PPROM (Preterm Premature Rupture of Membranes)

Preterm premature rupture of membranes, that is, either the complete breakage of the amniotic sac or leakage of amniotic fluid before 37 weeks of gestation (i.e., before

labor and before the fetus has reached maturity), occurs in about 2-3 percent of all pregnancies. The condition poses a potentially grave risk to the fetus which is likely to be delivered within one week of membrane rupture and face complications of prematurity and even death (preterm delivery). It also poses a serious risk to the mother (and fetus) who may develop chorioamnionitis—an infection of placental tissues which can lead to the death of both the mother and fetus within a very short time. “The main risk to mother and fetus in PPRM is the development of infection within the uterus, since the amniotic sac no longer serves as a barrier against infection. The burden on the mother and the fetus is the risk of infection, but depending on how early in pregnancy the rupture occurs, the risk of prematurity may be more significant for the fetus.”²⁰

Treatment for PPRM includes hospitalization, expectant management, monitoring for signs of infection, administration of antibiotics and possibly tocolytics to stop preterm labor, and induction of labor to resolve chorioamnionitis should that occur. Determination of appropriate treatment depends to a considerable degree on when PPRM occurs in the pregnancy (the earlier in the pregnancy, the less chance there is for fetal survival and the higher incidence there tends to be for infection), the clinical condition of the mother as well as her socio-economic reality. Later in the early part of the pregnancy, conservative management may reduce the risks of prematurity for the fetus, keeping in mind that the vast majority of women

proceed to active labor and delivery soon after PPRM. Few remain pregnant more than 3-4 weeks after.

Ethically, if infection develops, Directive 47 provides guidance. Labor and delivery may be induced. This would constitute an indirect abortion because it fulfills the conditions of the principle of double effect. As explained by Peter Cataldo and T. Murphy Goodwin: “If evidence of intrauterine infection develops, however, progressive, severe infection of the mother and the fetus can be expected within hours, a life-threatening situation for both. In this setting, induction of labor for maternal benefit is commonly recommended in practice, even though the fetus cannot be expected to survive.”²¹ But can induction of labor before twenty-three weeks’ gestation ever be ethically justified, they go on to ask? After noting that in Catholic moral teaching and tradition, induction of labor is evaluated by the principle of double effect, they explain: “In the case of PPRM with evidence of infection in the uterus, the intention of the physician inducing labor is to cure the infection by removing the infected placenta and membranes of the gestational sac. The good effects of curing the mother of ...PPROM are not caused by the death of the baby (third condition). ...[T]he removal of the offending organ, the placenta and membranes, allows survival of the mother, which would otherwise be in doubt (fourth condition).”²² Finally, they go on to say that there is ample published evidence that when there is no clinical or laboratory evidence of infection, “expectant management and use of antibiotics is an

acceptable course that can result in fetal survival and acceptable maternal morbidity.”²³

Sr. Jean deBlois and Fr. Kevin O’Rourke, in discussing the Directives in Part Four of the ERDs, offer the following advice in understanding and applying these Directives, especially those discussed here: “[A]ppropriate interpretation and application of the *Directives* also require adequate medical data and an understanding of the pathophysiology of the conditions involved. . . . For example, in seeking to observe the norms set forth in Directives 47, 48, and 53, one must know the physical condition of the person in question. It is important to note here that Directive 47 (treating a serious pathological condition of a pregnant woman) and 48 (treating an extrauterine pregnancy) do not seek to impose conclusions divorced from clinical data. Rather, they set parameters within which clinical data must be presented, analyzed, and acted on.”²⁴

In making decisions about a course of action in these crisis situations, there are multiple variables to consider including the medical condition of the mother, the age of gestation of the fetus, accepted standards of care for dealing with these situations, the level of clinical care that is available, the patient’s living and family situation, and the woman’s physical, emotional and psychological capacities, among others. These are so often highly complex and too often very tragic decisions. Of utmost importance, is doing what can be done for the well-being of both the fetus and the mother and

discerning that in light of the guidance provided by the Directives.

Conclusion

While some decisions about how to address complications early on in a pregnancy are relatively straightforward, others are highly complex both medically and ethically. This is due in part to the numerous variables at play, rapidly changing situations, the need so often for relatively quick decisions, and the fact that Catholic health care is committed to the well-being of both the mother and the fetus whose interests sometimes conflict.²⁵

Given this reality, the wisdom of deBlois and O’Rourke should be taken to heart by those who have a responsibility for assisting in these decisions. They conclude their discussion of Part Four of the Directives with the following advice: “Appropriate . . . respect for unborn human life requires much more than mere adherence to the prescriptions and proscriptions expressed in Part Four. Although specific directives set the parameters for determining appropriate action on behalf of human good, they do not exempt decision makers from reasoned analysis and conscientious decision making.” And they go on to say: “The nature of the materials addressed in Part Four should lead ethics committees [and, I might add, others who provide ethical guidance] in Catholic health care to educate themselves and ensure they understand the issues. Moreover, ethics committees should carry out ongoing educational activities to promote better understanding of the issues and help shape

organizational policy and practice in ways that promote the goods and values in question.”²⁶

¹ Lori R. Freedman and Debra Stulberg, “Conflicts in Care for Obstetric Complications in Catholic Hospitals,” *AJOB Primary Research* 4, no. 4 (2013): 1-10.

² Erik Eckholm, “Bishops Sued over Anti-Abortion Policies at Catholic Hospitals,” *The New York Times*, December 2, 2013, accessed at <http://www.nytimes.com/2013/12/03/us/lawsuit-challenges-anti-abortion-policies-at-catholic-hospitals.html?ref=unitedstatesconferenceofcatholicbishops>.

³ The Editorial Board, “When Bishops Direct Medical Care,” *The New York Times*, December 8, 2013, accessed at <http://www.nytimes.com/2013/12/03/us/lawsuit-challenges-anti-abortion-policies-at-catholic-hospitals.html?ref=unitedstatesconferenceofcatholicbishops&pagewanted=print>.

⁴ Sarah Kliff, “Catholic Hospitals Are Growing. What Will that Mean for Reproductive Health?,” *The Washington Post* (December 12, 2013) accessed at <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/12/02/catholic-hospitals-are-growing-what-will-that-mean-for-reproductive-health/>.

⁵ Debra B. Stulberg, Annie M. Dude, Irma Dahlquist, and Farr Curlin, “Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies,” *American Journal of Obstetrics and Gynecology* 207 (July 2012) 73e1-5.

⁶ Debra Stulberg, Ryan Lawrence, Jason Shattuck and Farr Curlin, “Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care,” *Journal of General Internal Medicine* 25, no. 7 (2010): 725-30.

⁷ Joel Hanel and Shane Benjamin, “ACLU: Mercy Anti-Abortion Policy Illegal,” *Durango Herald* (November 13, 2013), accessed at <http://www.durangoherald.com/apps/pbcs.dll/article?AID=/20131113/NEWS01/131119849/ACLU:-Mercy-anti-abortion-policy-illegal&template=printpicart>.

⁸ ACLU and MergerWatch, “Miscarriage of Medicine: The Growth of Catholic Hospitals and

the Threat to Reproductive Health Care,” December 2013, accessed at <https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf>.

⁹ Lori Freedman, “Bishops Run Catholic Hospitals—And Should Be Liable When Their Edicts Lead to Error: New Research into Medical Decisions at Church-Run Facilities,” *The New Republic* (January 1, 2014), accessed at <http://www.newrepublic.com/article/116034/catholic-hospitals-lawsuit-usccb-doctrines-determine-care>.

¹⁰ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Washington, DC: USCCB, fifth edition, 2009, Part Four, Introduction.

¹¹ *Ibid.*, Part Four, Directives 26, 27 and 28.

¹² Albert S. Moraczewski, OP, “Ectopic Pregnancy: B. Arguments in Favor of Salpingostomy and Methotrexate,” in Edward J. Furton et. al., eds., *Catholic Health Care Ethics: A Manual for Practitioners*, Philadelphia, PA: The National Catholic Bioethics Center, 2009, p. 122.

¹³ See, for example, William E. May, “Ectopic pregnancy: A. Arguments against Salpingostomy and methotrexate,” in Edward J. Furton, et. al., eds., *Catholic Health Care Ethics: A Manual for Practitioners*, Philadelphia, PA: The National Catholic Bioethics Center, 2009, pp. 119-12; Edward Furton, “The Direct Killing of the Innocent,” *Ethics and Medics* 35, no. 10 (October 2010): 1-2..

¹⁴ In addition to the article by Moraczewski cited above, see Peter Cataldo, “Ectopic Pregnancy,” in *New Catholic Encyclopedia Supplement 2009*, Rev. Bernard Marthaler, O.F.M., Conv., ed., Washington, D.C.: The Catholic University of America, 1009, pp. 284-286; Germaine Grisez, *The Way of the Lord Jesus*, vol. 2, *Living A Christian Life* (Quincy, IL: Franciscan Press, 1993), pp. 499-503; Kevin O’Rourke, “Applying the Directives: The Ethical and Religious Directives Concerning Three Medical Situations Require Some Elucidation,” *Health Progress* 79, no. 4 (July-August 1998): 64-66; Martin Rhonheimer, *Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancies*, edited by William F. Murphy, Washington, D.C.: Catholic

University of America Press, 2009, especially pp. 83-121.

¹⁵ Benedict Ashley, Jean deBlois, and Kevin O'Rourke, *Health Care Ethics: A Catholic Theological Analysis*, Washington, D.C.: Georgetown University Press, fifth edition, 2006, p. 82.

¹⁶ Furton, et al., eds., *Catholic Health Care Ethics*, p. 123.

¹⁷ Craig Gabriel, M.D. et al., "Management of Spontaneous Abortion," *American Family Physician* 72 (2005): 1243-50.

¹⁸ Ibid. See also Quynh Bui, "Management Options for Early Incomplete Miscarriage," *American Family Physician* 83 (February 1, 2011): 258-60; I. Casikar, et al., "Expectant Management of Spontaneous First-Trimester Miscarriage: Prospective Validation for the '2-week rule,'" *Ultrasound Obstetrics and Gynecology* 35 (2010): 223-227; B.A. Chen and M.D. Creinin, "Contemporary Management of Early Pregnancy Failure," *Clinics in Obstetrics and Gynecology* 50 (March 2007): 67-88; G. Condous, E. Okaro and T. Bourne, "The Conservative Management of Early Pregnancy Complications: A Review of the Literature," *Ultrasound Obstetrics and Gynecology* 22 (2003): 42-30; M.M. El-Sayed, S.A. Mohamed and M. H. Jones, "Expectant Management of First-Trimester Miscarriage," *Journal of Obstetrics and Gynecology* 29, no. 8 (November 2009):681-5; M. Wieringa-de Waard, et. al., "Patient Preferences for Expectant Management vs. Surgical Evacuation in First-Trimester Uncomplicated Miscarriage," *Journal of Clinical Epidemiology* 57 (February 2004): 167-73.

¹⁹ I am indebted to Michael Panicola, Ph.D., Senior Vice-President, Mission, Legal & Government Affairs, SSM Health Care, Saint Louis for these distinctions.

²⁰ Peter J. Cataldo and T. Murphy Goodwin, M.D., "Early Induction of labor," in *Catholic Health Care Ethics: A Manual for Practitioners*, ed. by Edward Furton, Peter Cataldo and Albert Moraczewski, O.P., Philadelphia: The National Catholic Bioethics Center, second edition, 2009, p. 112.

²¹ Ibid., p. 113.

²² Ibid.

²³ Ibid., pp. 112-113. See also, Sr. Jean deBlois, CSJ, PhD and Fr. Kevin O'Rourke, OP, JCD, "Care for the Beginning of Life," *Health Progress* 76, no. 7 (September-October 1995): 36-39, 40; reprinted in *Ethical and Religious Directives for Catholic Health Care Services: Seeking Understanding—A Collection of Selected Readings*, Saint Louis: The Catholic Health Association, 2003, pp. 27-32. The reprint is quoted here.

²⁴ deBlois and O'Rourke, p. 28.

²⁵ Cataldo and Goodwin, p. 111.

²⁶ deBlois and O'Rourke, p. 31.