CARE FOR THE BEGINNING OF LIFE

The Revised Ethical and Religious Directives *Discuss Abortion, Contraception, and Assisted Reproduction*

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CHA and the Center for Health Care Ethics at the Saint Louis University Health Sciences Center are collaborating to publish a series of articles on the Ethical and Religious Directives for Catholic Health Care Services. *This article is the fourth in the series, written by Sr. deBlois, CHA's senior associate for ethics, and Fr. O'Rourke, director of the Center for Health Care Ethics.*

Part 4 of the recently revised *Ethical and Religious Directives for Catholic Health Care Services (ERD)* deals with many important and, at times, controversial issues. Although the controversies are familiar to many persons in the Catholic health ministry, the principles and teaching underlying the issues are not always known or understood. As a result, conflicts often are heightened by an inadequate understanding and application of the *ERD* in concrete situations. Thus, before commenting on some of the specific directives, we must briefly discuss the underlying principles and the teaching that ground them.

PRINCIPLES AND UNDERLYING TEACHING

Two fundamental principles inform and shape this section of the *ERD*. First, Part 4 begins with a reaffirmation of the Church's steadfast commitment to human dignity. Realizing that the human being is created in the image of the Creator God and is destined for union with God, the Church calls for the utmost respect for every human life from the moment of conception onward. Church teaching has consistently rejected the suggestion that an embryo has no moral status. Once fertilization takes place, human life is present and must be respected "in an absolute way."[1]

Church teaching on respect for the dignity of the person stands in clear contrast to the prevalent secular notion that people earn or achieve dignity when they pass some arbitrary milestone, physiological or otherwise. The introduction to Part 4 says that life demands respect simply because it is human life. It is respect for the dignity of the human person that "inspires an abiding concern for the sanctity of human life." Directives 45 through 51 are very specific on the respect and protection due unborn human life.

Second, the Church, because of its devotion to human dignity, demands the "deepest respect" for the marriage covenant and the family, wherein life has its origins and can flourish. The Church's teaching on marriage and family life is rooted in the reality of the human being as created in the image of God and as sharing in God's creative

Summary Part 4 of the *Ethical and Religious Directives for Catholic Health Care Services*—which discusses such controversial issues as abortion, contraception, and assisted reproduction—is informed by a profound respect for human life and the institution of marriage.

The controversies are familiar. But many in Catholic healthcare may be less familiar with the principles underlying Church teaching on these issues.

Appropriate interpretation and application of these directives require that all concerned be educated in both the theological-ethical *and* the clinical dimensions of care giving.

Directives 38 through 43 deal with reproductive technologies such as in vitro fertilization and surrogacy. Directives 52 and 53 express the Church's consistent teaching on contraceptive interventions.

Directives 45 to 48, 50 to 51, and 54 reiterate the Church's firm stance on the inviolability of human life, including nascent human life. However, the directives also say that not all medical interventions resulting in fetal death are prohibited abortions.

However, appropriate regard for human life, marriage, and the family require more than mere adherence to the directives' prescriptions and proscriptions. Ethics committees in Catholic healthcare should study clinical data as well as theological materials.

power through marriage and conjugal love. Pope John Paul II writes in "The Christian Family in the Modern World":

> In its most profound reality, love is essentially a gift; and conjugal love, while leading the spouses to the reciprocal "knowledge" which makes them "one flesh," does not end with the couple, because it makes them capable of the greatest possible gift, the gift by which they become cooperators with God for giving life to a new human person.[2]

This teaching presumes a view of human sexuality diverging sharply from that of contemporary society. Although the humanism characteristic of modern culture accepts the proposal that sexuality has various dimensions or goods, it fails to recognize the interrelatedness of these dimensions. Church teaching, on the other hand, insists that the nature of the goods or values embedded in human sexuality demands that they be pursued and experienced in an integral manner. Moreover, because genital sexuality is a gift to be used both for self-fulfillment and for fostering and building community, it should be experienced only within the context of marriage. Since in this context the transmission of human life is an act of cocreation, it should be the result of a personal, bodily, and conscious act.[3] Conclusions about maintaining the integrity and goods of marriage and family are expressed in Directives 38 through 43, 52, and 53.

Interpretation and Application

Space does not permit a detailed analysis of this section of the *ERD*. However, specific directives warrant extended comment and some clarification with regard to implementation in given circumstances. Before addressing these, we need to note four points:

- First, appropriate interpretation and application of the directives in Part 4 often require an understanding of theological realities that may be unfamiliar to clinicians and others in the healthcare setting. Such persons may need to consult with a trained theologian or ethicist when trying to interpret and apply a given directive. For example, in determining the limits of appropriate cooperation in forming new partnerships (Directive 45) or the action consistent with the principle of double effect (Directives 47 and 48), healthcare professionals should consult with a person knowledgeable about the Catholic moral tradition.
- Second, appropriate interpretation and application of the *ERD* also require adequate medical data and an understanding of the pathophysiology of the conditions involved. Thus, in many circumstances, a clinician is better suited than a moral theologian or ethicist to determine the appropriateness of contemplated actions. 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 Directives 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 the broad parameters within which clinical data must be presented, analyzed, and acted on.
- This leads us to a third consideration. All those concerned with beginning-of-life issues should be educated in both the theological-ethical *and* the clinical dimensions of care giving. Such training is particularly important for ethics committee members charged with educating all those associated with the Catholic health ministry about the *ERD* and the teaching that informs them.
- Fourth, although the directives in this section provide a basis for appropriate respect for the goods of marriage and family within healthcare, they are *only* a foundation. Adequately protecting and fostering human dignity and family life requires attention to many other dimensions of human well-being and family life.

Commentary on Individual Directives

In Part 4 of the *ERD* specific directives address two distinct but interrelated concerns. Concern about *maintaining and promoting the integrity of marriage and the family* is addressed in Directives 38 to 43, which deal with reproductive technologies, and Directives 52 and 53, which address contraceptive and sterilizing interventions. Concerns about *protecting the lives of the unborn and the mother* are dealt with in Directives 45 to 48, 50 to 51, and 54.

Directives 38 to 43 As noted above, appropriate interpretation and application of these directives requires an understanding of the theological context from which they arise. The directives dealing with the reproductive technologies reject any treatment of a couple's infertility that does not respect

the integral relationship among the goods of sexual intercourse in marriage. This limits the ability of professionals affiliated with Catholic health facilities to address the needs of infertile couples.

Because of these limitations some persons claim that Catholic healthcare is insensitive to the needs of such couples. However, in addition to Church teaching on the technologies of assisted reproduction, a growing body of academic literature also questions the propriety of developing and using such interventions (e.g., in vitro fertilization, surrogacy).[4] Concerns include:

- The possibility of true informed consent on the part of infertile couples, who often are described as "desperate" in their quest for a child of their own
- The negative effects these technologies might have on intimacy in an already stressed marital relationship
- Quality control in an unregulated, lucrative, and growing industry
- The appropriateness of further development of such technologies in a healthcare system that continues to deny basic services to millions of Americans

The *ERD*'s negative assessment of the technologies of assisted reproduction should not lead one to conclude that a Catholic healthcare facility should offer *no* fertility services. On the contrary, the Church's commitment to marriage and family compels the Catholic health ministry to make available all appropriate interventions and to seek and develop ways to respond to the needs of infertile couples.

Directives 52 and 53 These directives express the Church's consistent teaching with regard to contraceptive interventions. Directive 52 says that promoting or condoning contraceptive practices among married couples is unacceptable because doing so can undermine the marital relationship. The directive counsels Catholic providers to offer clear alternatives to contraceptive interventions for married couples seeking such information. However, Directive 52 does not answer all questions a Catholic organization might have about the use of drugs to avoid pregnancy.

Consider the following case:

> A Catholic hospital sponsors an inner-city clinic that serves a predominantly indigent population. Many of the persons using the clinic are unmarried teenagers, and many of them abuse drugs. Clinic physicians and staff are confronted frequently with requests for birth control pills.

This case raises many questions. Can the clinic physicians prescribe "contraceptive drugs" to help prevent teenage pregnancy and pregnancy complicated by drug abuse? Can clinic physicians prescribe a contraceptive drug to a young woman who has a history of pregnancies ending in abortion?

Church teaching, which seeks to reinforce the dignity of the marital relationship, may be helpful in such situations, but it is not sufficient. For this reason, it is important to realize that the *ERD* are only a part of the broader moral tradition of the Church. We must refer to that broader teaching to resolve such questions. The assistance of a well-trained moral theologian or ethicist is essential in such cases.

Directives 45 to 48, 50 to 51, and 54 These directives reiterate the Church's firm stance on the inviolability of nascent human life. All actions that intend the death of a living human being are wholly inconsistent with adequate regard for the dignity of human life and cannot be tolerated in a Catholic health facility. The strength of this conviction is revealed in Directive 45 when it says that no abortion is to be performed in a Catholic facility "even based on the principle of material cooperation."

In addition, this directive cautions Catholic organizations about the potential for causing scandal if they do form partnerships or alliances with providers that offer abortion services. Note, however, that the potential for scandal does not of

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necessity preclude forming such associations. But Catholic organizations should take adequate care to avoid causing scandal, primarily through open and honest education of all involved as to the reason for and limits on the proposed association.

Directive 47 notes the appropriateness of interventions to treat a serious pathological condition of the mother, even when a nonviable fetus will die as a result. Appropriate application of this directive requires at least two things:

1. Adequate data about the medical condition of the mother and fetus
2. An understanding of how the proposed intervention will address the medical condition

Too often, well-meaning but uninformed observers claim that all interventions resulting in fetal death constitute a *direct*, and therefore prohibited, abortion. Such an appraisal often is based on the erroneous conclusion that the term "abortion" conveys only and always a moral assessment. Such a conclusion is evidence of a lack of precision in understanding both moral and medical terminology.

Consider the following case:

> A 23-year-old woman is admitted to the emergency department with abdominal cramps and fever. She is 19 weeks' pregnant, and fetal heart tones are present. Cervical membranes are bulging, and amniotic fluid is leaking. The cervix is dilated 2 to 3 cm, and fetal parts are palpable through the cervix. After appropriate consultation, the diagnosis of "probable uterine infection and threatened abortion" is made.
>
> The physician makes reasonable efforts to sustain the pregnancy and treat the infection, but with little success. The physician recommends artificial rupture of the membranes and drug-induced labor.

Directive 47 is helpful here, primarily because it emphasizes that the moral judgment in such a case requires adequate medical data. In addition, though Directive 47 does not spell out the terms of the assessment, it does indicate briefly the manner in which the assessment should be done.

Reviewing the case in the light of the directive, we can draw the following conclusions:

- The physicians performed the intervention (membrane rupture and induction of labor) so they could empty the patient's uterus of its contents, treat the infection, and complete a labor process that, although it was ineffective, had already begun.
- To induce labor, the physicians used the only drug that would alleviate the patient's pathological condition, the uterine infection. The drug helped cure the infection (a treatment that was directly intended) and brought on delivery of a previable fetus (an outcome that was not directly intended).
- Fetal survival was not possible in this case because of the worsening uterine infection. Moreover, inevitable abortion was indicated by the protruding fetal part.
- The resulting fetal death was indirect.

Directive 48 succinctly defines the limits within which the moral assessment of treating extrauterine pregnancy must take place. The sole criterion proposed is that treatment must not constitute a direct abortion. Thus it is left up to the clinician—who understands both the pathophysiology involved in extrauterine (ectopic) pregnancy and the mechanisms of the interventions used to address it—to assess the propriety of a proposed intervention. For example, in the case of ectopic pregnancy, the threat to the mother is posed by the trophoblastic tissue as it invades the wall of the fallopian tube.[5] Left untreated, the tube may rupture with resultant hemorrhage and, in some cases, the mother's death. Until fairly recently, the moral assessment was made in such cases by defining the tube itself as "pathological" and thus accepting its surgical excision as a morally acceptable intervention consistent with the principle of double effect.

The problem, of course, was that although such an intervention cured the pathological condition, it also seriously limited the woman's ability to conceive and bear other children. Recent advances in both diagnostic capabilities and treatment modalities allow for detection of an ectopic pregnancy well before significant symptoms develop. Newer interventions directly address the pathological condition (understood now as the point of attachment of the embryo to the wall of the fallopian tube), cure the condition, *and* preserve fertility. As in the past, the resulting death of the embryo is deemed an indirect consequence. It is obvious that such an assessment cannot be made without sufficient clinical data.

Adherence Is Not Enough

Three things should be clear from this brief discussion of Part 4 of the *ERD*:

- It is a section that requires serious reflection

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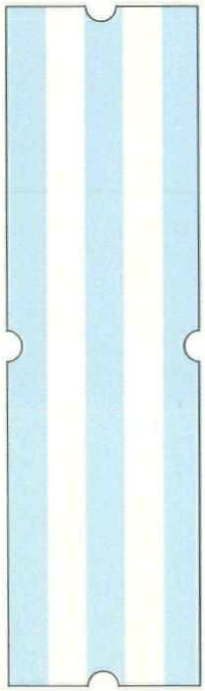

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us solve the current healthcare crisis. But Catholic social teachings may well provide the principles on which healthcare can be restructured for the years ahead.

We must remember, however, that an analysis of healthcare delivery based on Catholic social teachings will have as heavy an impact on *Catholic* healthcare as on non-Catholic forms. It is indeed possible that, in some circumstances, Catholic healthcare may have helped develop practices and standards that are at odds with its own teachings. That should not stop us from employing these teachings for a structural reexamination of Catholic healthcare. It will be painful, but it must be done. □

NOTES

1. Richard A. McCormick, "The Catholic Hospital Today: Mission Impossible?" *Origins*, March 16, 1995, pp. 648-653.
2. On principleism, see Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Oxford University Press, New York City, 1983; see also E. DuBose, R. Hamel, and L. O'Connell, *A Matter of Principles? Ferment in U.S. Bioethics*, Trinity Press International, Valley Forge, PA, 1994.
3. See, for example, D. Hollenbach, *Claims and Conflict: Retrieving and Renewing the Catholic Human Rights Tradition*, Paulist Press, Mahwah, NJ, 1979; P. Henriot, E. DeBerri, and M. Schultheis, *Catholic Social Teaching: Our Best Kept Secret*, Orbis Books, New York City, 1985; and M. Schuck, *That They Be One: The Social Teaching of the Papal Encyclicals, 1740-1989*, Georgetown University Press, Washington, DC, 1991.
4. National Conference of Catholic Bishops, *Health and Health Care*, U.S. Catholic Conference, Washington, DC, 1981.
5. See, for example, D. Brock and N. Daniels, "Ethical Foundations of the Clinton Administration's Proposed Health Care System," *JAMA*, April 20, 1994, pp. 1189-1196.
6. Catholic Health Association, *With Justice for All? The Ethics of Healthcare Rationing*, St. Louis, 1991.

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and further study, including inquiry into theological as well as clinical data and materials.

• Appropriate regard for the goods of marriage and family and respect for unborn human life require much more than mere adherence to the prescriptions and proscriptions expressed in Part 4. 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.

• The nature of the material addressed in Part 4 should lead ethics committees in Catholic healthcare 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. □

NOTES

1. Congregation for the Doctrine of the Faith, Instruction on *Respect for Human Life in Its Origin and On the Dignity of Procreation*, Ignatius Press, San Francisco, 1987, p. 12.
2. Pope John Paul II, "The Christian Family in the Modern World," in Austin Flannery, ed., *Vatican Council II: More Post Concilior Documents*, vol. 2, Costello Publishing, Northport, NY, 1982.
3. Congregation for the Doctrine of the Faith, p. 9.
4. See, for example, Leon Kass, *Toward a More Natural Science: Biology and Human Affairs*, Free Press, New York City, 1985; Paul Lauritzen, *Pursuing Parenthood: Ethical Issues in Assisted Reproduction*, Indiana University Press, Indianapolis, 1993; Rita Arditti, Renate Klein, and Shelley Minden, eds., *Test-Tube Women: What Future for Motherhood?* Pandora Press, London, 1984.
5. Sandra Carson and John Buster, "Ectopic Pregnancy," *New England Journal of Medicine*, vol. 329, no. 16, pp. 1,174-1,180.