Abstract. A recent consensus statement claimed that double effect can justify induction of labor before viability when life-threatening pathological complications arise from the interaction of a normally functioning placenta with the diseased heart of the mother. The authors of this essay agree. They analyze two pieces published in response, using the framework of the first and fourth criteria of double effect; identify and attempt to clarify inaccuracies and other sources of ambiguity in the discussion; and acknowledge practical implications for other scenarios previously considered illicit. They conclude that more thorough medical and moral discussion is needed regarding the fourth criterion, even if the act itself is not intrinsically evil. National Catholic Bioethics Quarterly 15.2 (Summer 2015): 251–261.

In an article on early induction of labor, T. Murphy Goodwin and Peter Cataldo make a case for the applicability of the principle of double effect to the induction of labor before viability in some scenarios of preterm premature rupture of membranes (PPROM) and pre-eclampsia. They note that the disease process in pre-eclampsia is related to placental malfunction and that PPROM leads to severe intrauterine infection. Other inductions before viability involving pathological tissue in the uterus,
such as chorioamnionitis and HELLP syndrome, have likewise become accepted instances for applying the principle of double effect. However, as Goodwin and Cataldo note, “whether the principle of double effect can be applied when the normal homeostatic changes of pregnancy induced by the placenta place a mother’s life at risk is worthy of further discussion.” In other words, cases in which the pathology addressed by inducing labor is not found within the uterus remain unsettled.

A consensus statement published in 2014 by participants in a colloquium sponsored by Ascension Health has advanced this much-needed discussion by arguing that the induction of labor prior to fetal viability may be licit in certain rare cases even when there is no pathological tissue in the uterus. The statement discusses peripartum cardiomyopathy (PPCM) complicated by subsequent pregnancy (PPCM+P) and concludes that “medical induction of labor prior to fetal viability, when necessary to eliminate a grave and present danger posed by a pathological and life-threatening condition resulting from the interaction of a normally functioning placenta with the diseased and weakened heart of the mother, is consistent with directive 47 [of the Ethical and Religious Directives], with Church teaching, and with the Catholic moral tradition.”

We are both in agreement with the conclusion of the consensus statement. We do not believe that the induction of labor prior to fetal viability is intrinsically evil, and we do not consider the physical “location” of the pathology to be significant in applying the principle of double effect. We agree that the complications—not the underlying PPCM—are directly treated by inducing labor. If the action is not intrinsically evil and if it directly addresses the pathology at hand, then double effect should be applicable. We note that the fourth condition of double effect regarding sufficient reason—including due proportion of the effects, lack of better alternatives and due diligence in seeking them, and moral certitude concerning the imminence and gravity of the threat—must always be met in specific cases using clinical and moral judgment, as indicated in the statement conclusion by such phrases as “when necessary,” “grave and present danger,” and “life-threatening condition.” We hold that the fourth condition of double effect cannot be considered satisfied in advance on the sole basis of medical data regarding outcomes.

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6 Ibid., 488.
8 This is not only to prevent unwarranted early interventions, but also to acknowledge the severity of particular clinical cases that might not be reflected in the literature because of underreporting or confounding variables, such as terminations in the most serious cases or prior to the onset of clear symptoms.
The Act Itself and Sufficient Reason

Jay Bringman and Robert Shabanowitz recently published a critique of the consensus statement.9 The current issue of the *NCBQ* includes a rebuttal to that critique, coauthored by Peter Cataldo and most of the signatories of the statement.10 The current issue also includes a clarifying letter from Rev. Nicanor Austriaco, OP,11 a signatory of the original statement and a coauthor of the rebuttal, whose past work was invoked by Bringman and Shabanowitz in support of their critique.

We aim to advance the debate in several ways. First, we will identify what we believe are the key areas of moral contention. We will then acknowledge certain inadequacies in the Bringman and Shabanowitz critique, some of which the rebuttal by Cataldo et al. has captured and clarified, and we will note some limitations of the rebuttal. Finally, we will highlight important contributions to the discussion by Bringman and Shabanowitz.

The most serious challenges to the conclusion of the statement are of two basic types: challenges to the first criterion of the principle of double effect, which is whether the act itself is intrinsically evil, and challenges to the fourth criterion, which is the need for a sufficient reason.12 Challenges of the first type question whether the principle of double effect is applicable at all: if the first condition is not met, then the principle is simply *not applicable*. Challenges of the second type admit that the principle may be applicable in some cases but question under what specific circumstances it applies.

The critique by Bringman and Shabanowitz does not frame its response in these categories, but we believe they fit. In agreement with the authors of the rebuttal and the clarification, we think Bringman and Shabanowitz’s challenges to the first criterion fail, and we defend the applicability of the statement’s conclusion. The challenges of Bringman and Shabanowitz to the fourth criterion remain. The rebuttal by Cataldo et al. does not address or resolve all of these, and misses an opportunity to examine the medical literature more critically and narrow down the circumstances in which its general conclusion might apply in practice.

The Specific Threat and the Act in Question

The rebuttal identifies several errors in the critique by Bringman and Shabanowitz. The two most important are its misunderstanding of the specific threat named in the statement and its lack of a clear distinction between direct attacks on the

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12 These correspond to the two areas identified in Di Camillo, “Induction of Labor,” 3.
child and the induction of labor. The former pertains to the fourth criterion of double effect, since it concerns the effectiveness of induction for addressing the pathological condition. The latter pertains to the first criterion of double effect, since it concerns the very nature of the act in question.

Bringman and Shabanowitz do not accurately focus their arguments against the statement’s claim that induction eliminates the “specific threat” to the pregnant woman. They correctly cite the statement’s description of the threat as the interaction of the placental hormones with the maternal heart (PPCM+P), including the statement’s acknowledgment that the underlying heart condition (PPCM) is not cured, but then they cite the continued presence of the PPCM after pregnancy as evidence that the specific threat remains. In short, they seem to confound PPCM, which remains after pregnancy, with the pregnancy-induced complications of PPCM, which cease when the placenta detaches from the uterine wall. The rebuttal by Cataldo provides thorough clarification on this point. The life-threatening complications subside when the placenta deplants, addressing the specific threat, but the PPCM remains.

More significantly, the Bringman and Shabanowitz critique does not maintain a clear distinction between direct abortions, including any surgical attack on the child, and the induction of labor through pharmacological intervention. Consequently, its strongest attempts to challenge the first criterion of double effect do not hold up. The critique invokes the reasoning of Austriaco regarding surgical placentectomy, or dilation and curettage abortion, in a case of pulmonary arterial hypertension as evidence against the statement’s conclusion. The rebuttal by Cataldo et al. and the clarification by Austriaco amply reiterate that the procedure proposed in the statement is an induction of labor, not a surgical abortion. The statement itself affirmed that any surgical dismemberment of the child would be intrinsically evil, failing the first criterion of double effect.

In the procedure proposed in the statement, the placenta is not the target of a surgical “removal,” as in a placentectomy; rather, the induction of labor results in

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13 See Colloquium, “Medical Intervention,” 481–482, specifically n. 7.
14 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 34.
16 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 35–37. The primary moral issues revolve around uses of the vague terms “abortion” and “abortive act” and more specific terms such as “labor induction abortion,” “removing . . . a healthy organ,” and “removal of the placenta,” all of which relate to whether the action is a direct attack on the child and, by implication, whether it fails the first condition of double effect.
17 See Nicanor Austriaco, “Abortion in a Case of Pulmonary Arterial Hypertension,” National Catholic Bioethics Quarterly 11.3 (Autumn 2011): 503–518. The author notes that “first, and significantly for the moral analysis that will follow, the exact medical procedure performed here was a placentectomy” (506) and refers to “the dilation and curettage (D&C) procedure used in the Phoenix abortion case” (515).
18 Cataldo et al., “Deplantation of the Placenta”; and Austriaco, “Resolving Crisis Pregnancies.”
placental detachment from the uterus.\footnote{Cataldo et al., “Deplantation of the Placenta,” 249–250: “The placenta nevertheless separates as a direct result of the induction of labor.”} This “deplantation”\footnote{Colloquium, “Medical Intervention,” 482, n. 7.} is what specifically results in the beneficial effect for the mother. Whether the placenta is a vital organ of the child does not change the application of double effect: neither the fetus nor the placenta is directly targeted for destruction in a medical induction of labor. Thus, while we agree with the premise of Bringman and Shabanowitz that the placenta is a vital organ of the child prior to viability, we also agree with the claim in the statement that induction of labor is not a direct attack on the child.

### Confusion from Misdirected Assumptions and Missed Replies

The rebuttal by Cataldo et al. advances the discussion, but we believe it also introduces confusion in several ways. It reduces the critique by Bringman and Shabanowitz to a refutation of the statement’s conclusion about the applicability of the principle of double effect, replies to purported assumptions and claims that are not made in the critique, and does not thoroughly engage the concerns expressed in the critique about the fourth condition of double effect, which is important to ensuring a more realistic framework for clinical guidance.

Bringman writes as a maternal–fetal medicine specialist and Shabanowitz as an ethicist and clinic director. Both authors demonstrate familiarity with moral argumentation on early induction of labor, but neither writes as a specialist in the Catholic moral tradition. They speak from experience, raise practical moral concerns, commend the statement’s authors for addressing the topic, and express their openness to clarification: “We have presented these arguments to promote continued discussion and debate.”\footnote{Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 37.} Their stated purpose is to “suggest a more realistic framework for analysis.”\footnote{Ibid., 31.}

Despite these articulated aims of Bringman and Shabanowitz, the rebuttal effectively reduces their critique to an attempted refutation of the statement. In their rebuttal, Cataldo et al. claim that the statement’s fundamental conclusion has not been disproved, and engage in only a limited way with the critique’s clinical data and with more nuanced practical conditions in which the conclusion would be likely to apply: “This response . . . has . . . argued that the assumptions prevent Bringman and Shabanowitz from successfully refuting the statement.”\footnote{Cataldo et al., “Deplantation of the Placenta,” 250.} But Bringman and Shabanowitz’s purposes cannot be reduced to refutation: challenges to the first criterion are attempted refutations, whereas challenges to the fourth concern the manner and mode of applicability, hopefully with insights for clinical guidance.

The rebuttal by Cataldo et al. at times distracts the reader from key moral concerns, pointing to claims or assumptions that Bringman and Shabanowitz did not make. For example, it says that Bringman and Shabanowitz “wrongly assume
that the meaning of the term ‘present’ . . . in the phrase ‘grave and present danger’ is exhausted by a temporal meaning that is tied to actual deaths,” and so believe that “there is no basis for the statement authors to claim that danger exists at the time of a specific pregnancy.”

It is not clear whether Bringman and Shabanowitz made such a restrictive assumption. Their actual claim is straightforward: “The literature evaluating the outcomes in subsequent PPCM pregnancies does not support an interpretation of ‘grave and present danger’ and the perceived necessity to terminate.”

The final determination is case-specific and requires the physician’s judgment, but there is no reason to expect a priori that the danger will be grave and present based on the medical literature alone. This is relevant to assessments of the fourth criterion of double effect.

A claim the rebuttal accurately attributes to Bringman and Shabanowitz is “that a normally functioning placenta is by definition morally precluded from being directly removed.” While those were not its words, the critique does claim that “the placenta is an essential ‘organ’ of the fetus,” and so the “removal” of the healthy placenta prior to viability would be “equivalent to the removal of a healthy and normally functioning fetal heart.”

We believe this claim to be accurate, though unhelpful. The act in question is not a direct “removal” of the placenta but the induction of labor. The metaphysical status of the placenta is therefore moot. The rebuttal by Cataldo et al. causes confusion about the act and the moral reasoning by addressing this claim about placental identity.

The rebuttal also ascribes to the critique the assumption “that because the placenta functions normally in PPCM+P it has nothing to do de facto with the diseased heart of the mother,” a conclusion of the broader supposed assumption “that the normality of an organ precludes it from contributing to a pathological state.”

The rebuttal goes even further in ascribing to Bringman and Shabanowitz the “claim that the pathologic cardiac tissue, and the per se threat it presents, is the exclusive

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25 Ibid., 245.
26 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 34.
27 Bringman and Shabanowitz demonstrate this in the following claim: “We believe that in most cases of PPCM, you could safely prolong pregnancy through viability and delivery of the child” (“The Placenta as an Organ,” 33). If this is true, then the fourth condition would not likely be met in most cases.
29 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 35.
30 Cataldo et al., “Deplantation of the Placenta,” 248, note 21, where the rebuttal itself notes that the metaphysical status of the placenta “was not included as an essential component of the statement.” See also ibid., 250; and Austriaco, “Resolving Crisis Pregnancies,” 209, which shows how the statement is consonant with the position that the placenta is a vital organ of the child prior to viability.
31 Cataldo et al., “Deplantation of the Placenta,” 247. Bringman and Shabanowitz state that “the underlying pathology in PPCM . . . has nothing to do with the placenta” (“The Placenta as an Organ of the Fetus,” 35, emphasis added), which is different from claiming that the placenta has nothing to do with the diseased heart in PPCM+P.
morally relevant biological fact.” If this were true, the induction of labor before viability would simply be ruled out a priori because it does not treat pathological cardiac tissue, and there would be no moral relevance to whether it could save the woman’s life. Yet the critique discusses medical data about the outcomes of PPCM with subsequent pregnancy, including its connection with a perceived need for termination, which means that Bringman and Shabanowitz must consider these facts morally relevant as well.

As already indicated, the rebuttal by Cataldo et al. does not fully engage the medical data presented by Bringman and Shabanowitz in their critique, leaving concerns about support in the literature for the likelihood of meeting the fourth criterion of double effect. The critique’s claims about the ineffectiveness of termination of pregnancy, admittedly misidentifying the specific threat, nonetheless speak to it indirectly in terms of maternal survival during pregnancy. If few or no women have died of PPCM+P prior to fetal viability, there is little reason to expect a sufficient reason to induce labor before viability. While the rebuttal refutes the critique’s claim that there is “no citation where a maternal death occurred during that subsequent pregnancy,” pointing to three studies, there are limits to the significance of the data. For example, one study indicates only two deaths during pregnancy, without indicating whether these were before viability, out of over one hundred total PPCM deaths, with data going back about twenty years; another study cites only one such death, but it occurred during delivery at a post-viability gestational age of twenty-seven weeks; and the last study lists cardiomyopathy as the leading cause of pregnancy-related deaths, but does not identify how many deaths occurred during pregnancy.

The relevant consideration is that reports of maternal death during pregnancy are extremely rare in the available literature. The fact that there were two definite cases in the past twenty years does not deny this underlying point, which the critique by Bringman and Shabanowitz also supports with data showing no maternal deaths during pregnancy in multiple recent studies, most with sample sizes above thirty and one above one hundred. The rebuttal by Cataldo et al. does not respond to the data

33 Ibid., 242.
34 This does not mean there cannot be a sufficient reason in rare, exceptional cases, based on the clinical experience and expertise of a specialist, but that such cases are highly unlikely.
35 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 32.
36 Cataldo et al., “Deplantation of the Placenta,” 246, notes 11 and 12.
in any of these studies or discuss whether or how it might relate to establishing the likelihood of a sufficient reason for induction of labor before viability.41

The critique by Bringman and Shabanowitz also notes that there is little information about terminations of pregnancy, particularly clinical symptoms at the time of termination,42 which might indicate whether the terminations reported would have been considered necessary to save the mother’s life. It observes that there are no cases where a patient had the severe symptoms outlined in the statement’s hypothetical case at only six weeks’ gestation,43 which relates to the likelihood of sufficient reason. Most significantly, it claims that there is “no direct evidence to support that early termination mitigates the [grave] danger.”44 Failing such support in the literature, the assessment of whether there is a sufficient reason to induce labor in specific cases—including moral certitude of the grave and present danger of death—devolves almost exclusively to the individual physician’s clinical judgment. This does not invalidate the judgment, but it places a serious burden on the clinician while leaving significant room for misapplications or abuse.

Practical Implications and the Need for Clarity

The critique by Bringman and Shabanowitz establishes a more realistic framework for analysis in three ways. First, it notes the implications for analogous scenarios involving different underlying pathologies of the mother that are complicated by the demands of pregnancy. Second, it highlights the ambiguity of the term “deplantation” and the emphasis on the placenta in the statement’s argumentation. Third, it points to unresolved concerns about satisfying the condition of sufficient reason in practice.


41 Some of the studies cited by Bringman and Shabanowitz are referenced by Cataldo et al. in footnote 7 on page 246, but only as evidence that the interaction of a healthy organ with a non-healthy organ exacerbates or causes the specific threat.

42 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 32–33.

43 Ibid., 32.

44 Ibid., 34. Deaths are reported after delivery in most of the studies, sometimes within just weeks or months, but survival through delivery eliminates the vital conflict between mother and child.
The first two deal with the first criterion of double effect (the act itself), while the third deals with the fourth criterion (proportionate reason and lack of alternatives).

The rebuttal by Cataldo et al. considers the following claim in the critique to be a non sequitur: “In every situation where there is a normally functioning placenta and uterus acting on any diseased maternal organ, there would exist an argument for allowing an abortion to save the life of the mother.”45 To the contrary, we believe the claim to be an important contribution of the critique. It is accurate if “abortion” is understood to mean “induction of labor,” which is the act in question. 46 If the induction of labor before viability to eliminate the life-threatening pregnancy-related complications of PPCM is not intrinsically evil, and so could be justified with the satisfaction of the other criteria of double effect, then the induction of labor before viability may also be licit in cases of pulmonary arterial hypertension, diabetes, and any other condition that becomes life-threatening as a result of the normal demands of pregnancy. 47 If there is something unique about PPCM that would prevent applying the reasoning to other underlying pathologies, the rebuttal has not addressed it. This is a consequence for clinical practice that should be acknowledged, given the aversion in the moral tradition to induction before viability when there is a maternal pathology but a healthy pregnancy. 48

The critique by Bringman and Shabanowitz also points to a linguistic ambiguity fostered by the statement. The critique undeniably errs by confusing the statement’s claims about the induction of labor with claims about removing or otherwise attacking the placenta. 49 This reflects confusion about the nature of the act. But while the statement explicitly uses the term “medical induction of labor” to describe the action that may be justified by double effect, 50 it also frequently describes the action in placenta-centric terms such as “placental deplantation,” introducing ambiguity about the moral act. 51 The placenta-focused definition of the moral object does not


46 It should be evident that if “abortion” means “direct abortion,” then the claim is unfounded: the statement explicitly rejects surgical abortion and any other direct attack on the child. The only interpretation of “abortion” that makes the most sense here is “induction of labor.”

47 This consequence acknowledged by Bringman and Shabanowitz is also noted in Di Camillo, “Induction of Labor and Vital Conflicts,” 1.

48 See USCCB Committee on Doctrine, “The Distinction between Direct Abortion and Legitimate Medical Procedures,” June 23, 2010; and Henry Denzinger, The Sources of Catholic Dogma, trans. Roy J. Defferrari (Fitzwilliam, NH: Loreto Publications, 2010), nn. 1889–1890a. (The Defferrari is an English translation of Denzinger’s Enchiridion Symbolorum, 30th ed., ed. Karl Rahner [Freiburg, Germany: Herder, 1954]). These documents seem to indicate that the induction of labor is illicit when the pathological state being addressed arises from the healthy pregnancy. See also Pius XII, Address to Associations of Families (November 26, 1951).

49 The appeals to Austriaco’s reasoning on pulmonary arterial hypertension demonstrate this confusion, which is clarified in Austriaco, “Resolving Crisis Pregnancies.”


51 See ibid.: “such an intervention of placental deplantation” (481–482, n. 7) and “deplanting the placenta from the uterus” (485, n. 15).
help in this regard: “the triggering of uterine contractions to deplant the placenta in order to eliminate the placenta’s pathology-inducing interaction with the weakened heart of the mother.”52 We do not contest here this definition of the moral object, nor the importance of clarifying the medical and moral significance of the role of the placenta in the mother’s pathological state, but simply note that the language of “placental deplantation” may be cause for confusion about the proposed intervention and why it could be morally licit. As if implicitly acknowledging this ambiguity, the rebuttal by Cataldo et al. seems to focus its use of language more on induction of labor than placental deplantation.53

Finally, the critique by Bringman and Shabanowitz expresses a serious concluding concern about the statement in relation to the fourth criterion: “Without robust analysis, we set the stage for the acceptance of termination when the mother’s life is erroneously perceived to be in great danger; this may artificially strengthen the justification for abortion.”54 Despite the conflation of placentectomy with induction of labor, the concern remains valid, because it speaks to the assessment of danger. While the statement affirms that induction could only be licit in the very rare cases where there is moral certitude that it is “necessary to eliminate a grave and present danger” to the mother’s and child’s lives,55 translating this assertion into sound practices and policies requires further discussion about specific medical literature, clinical markers, and other information that might contribute to case-based prudential judgments about the necessity and urgency of intervention and possible alternatives. It is in this light, particularly considering the statement’s goal of providing a moral basis for clinical guidance,56 that we believe the critique’s conclusion about the statement is on target: “It neglects a more rigorous medical and ethical analysis.”57 The greater rigor needed is in relation to specifics about meeting the fourth criterion of double effect, not showing that it meets the first.

Further Moral Analysis Needed

The critique by Bringman and Shabanowitz, the rebuttal by Cataldo et al., and the clarification by Austriaco provide important contributions to this ongoing discussion, for which we are grateful. For the purposes of clarity about the act in question,

52 Colloquium, “Medical Intervention,” 485–486, n.19(i). It refers to the “medical induction of labor” as the “exterior act.”

53 See Cataldo et al., “Deplantation of the Placenta”: “the moral justification of early induction of labor” (242) and “the act of inducing labor is not intrinsically evil” (249), “the death of the fetus remains a . . . bad effect of the act of induction of labor, whose nature is not intrinsically evil” (249), and “the placenta nevertheless separates as a direct result of induction of labor” (249–250). The conclusion returns to describing it as “the act of ‘deplantation’” (250).

54 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 37.


56 Ibid.: “It is also intended to provide the moral basis and guidance for developing clinical guidelines for maternal–fetal vital conflict that are consistent with Catholic Church teaching and the medical standard of care” (478).

57 Bringman and Shabanowitz, “The Placenta as an Organ of the Fetus,” 37.
we believe that using the terminology of “induction of labor” is clearer than the language of “placental deplantation,” although both are used by the statement signatories. While we believe that the first criterion of double effect is met for inducing labor before viability in cases of life-threatening pregnancy-related complications of PPCM, the fourth criterion requires closer attention. The actual fulfillment of this criterion requires case-based judgments that cannot be determined a priori on the basis of past data or a generic analysis. The moral terms for those judgments, and the clinical data to guide them, should continue to be more thoroughly mined. The severity and rarity of these situations cannot be emphasized enough. The goal of establishing clinical guidelines demands this additional level of detailed analysis, particularly as this line of reasoning is expected to be invoked in analogous situations involving different underlying pathologies complicated by pregnancy.