The Placenta as an Organ of the Fetus

A Response to the Consensus Statement on Maternal–Fetal Conflict

Jay J. Bringman, MD, and Robert B. Shabanowitz

Abstract. The authors respond to a recent consensus statement on maternal–fetal vital conflicts. Sound ethical analysis must depend on accurate medical facts, but there appear to be inconsistencies in the medical analysis. The consensus statement says that the specific threat to the health of the mother immediately subsides following detachment of the placenta from the uterus. The authors refute this assertion, since death from peripartum cardiomyopathy may occur months to years following delivery of the neonate or following termination. The authors assert further that the placenta is an organ of the fetus and that any act on the placenta is a direct act on the fetus itself. National Catholic Bioethics Quarterly 15.1 (Spring 2015): 31–37.

We would like to discuss several issues regarding the recent article titled, “Medical Intervention in Cases of Maternal–Fetal Vital Conflicts.” We realize, from the outset, that this is a paradigm case and suggest a more realistic framework for

Jay J. Bringman, MD, MBA, FACOG, is a specialist in maternal–fetal medicine at Geisinger Medical Center in Danville, Pennsylvania. Robert B. Shabanowitz, PhD, is the director of the ART/Andrology Laboratories at Geisinger Medical Center.


©2015 The National Catholic Bioethics Center 31
analysis. Therefore, some of our criticisms are made specifically within the setting of peripartum cardiomyopathy (PPCM), while others are made within a more general framework.

**The Medical Literature**

Sound ethical analysis is dependent on facts. This is especially true in defending a position in medical ethics. This first step, therefore, is often the most difficult. In part, our discomfort with the consensus statement is based on what we believe are inconsistencies with the medical analysis. Regardless of the case that is to be analyzed, it is imperative for the medical facts to be accurate.

There are several studies in the medical literature that report outcomes of patients in a subsequent pregnancy (i.e., a second pregnancy) after diagnosis with PPCM. We found no citation where a maternal death occurred during that subsequent pregnancy. Maternal deaths were reported, but they occurred after the birth of a child. In one of the largest reported series of subsequent pregnancies following a diagnosis of PPCM, James Fett, Karie Fristoe, and Serena Welsh report only one maternal death among sixty-one post-PPCM pregnancies; this patient died one month postpartum. They do not report on fetal or neonatal outcomes and do not report on any “termination rates” in this population.

The authors of the consensus statement presented a very severe case of PPCM. We could not locate a case in the literature where a patient developed symptoms at six weeks’ gestation with that severity. In an earlier study, James Fett, Len Christie, and Joseph Murphy report a series of sixteen identified cases of PPCM in a subsequent pregnancy. Against medical advice, all but one patient became pregnant before full recovery of left ventricular systolic function from the previous pregnancy. No patients died during the subsequent pregnancy, and one patient died of severe heart failure ten months after delivery. In eight of the subsequent pregnancies, the patient experienced worsening heart failure; Fett et al. do not report any cases of termination in these pregnancies.

In a study evaluating prognostic factors for long-term maternal outcome, Mourina Habli et al. report that of thirty-seven patients who had a subsequent pregnancy following a diagnosis of PPCM, sixteen patients chose to terminate at an average gestational age often weeks. Although the patients may have been symptomatic at the time of termination, this information was not reported by the authors. Of the twenty-one who elected to continue the pregnancy, six had worsening symptoms of

---


heart failure. The average gestational age at delivery was 36.8 weeks, and there were no maternal or perinatal deaths in this group.

Perinatal mortality rates for pregnancies complicated by PPCM are also very low. In a study reported in the New England Journal of Medicine that included forty-four women with PPCM in a subsequent pregnancy, Uri Elkayam et al. report no perinatal mortality in those patients who chose not to abort. In sixteen seriously compromised patients, as defined by not having return of left ventricular function prior to the subsequent pregnancy, there were three deaths. All of these deaths occurred after delivery. One patient died at one month and two died at two years following delivery. The authors of this study did not speculate whether an abortion would have prevented any of these maternal deaths. Nine abortions were performed, five of which were therapeutic with the intent to improve the maternal condition.

In a later publication from 2014, Elkayam reports on the nine patients who chose abortion. There was a 7 percent decrease in left ventricular ejection fraction in these patients. In fact, the decrease in ejection fraction was smaller than the decrease seen in those patients who did not choose to abort. It is difficult to extrapolate with any certainty the overall clinical severity at the time of the termination. In this same publication, Elkayam also reports on outcomes of pregnancies that ended in termination in the Habli et al. study. In the eight patients who underwent early abortions, the clinical scenario was described as “no end stage cardiac disease.” Despite the early abortion in these women, five were listed for heart transplantation. Elkayam concludes, “Although these available data are limited by the small number of patients and lack of information, and are not sufficient to establish firm conclusions, it seems that in patients with severe [left ventricle] dysfunction, early termination of [subsequent pregnancy] may prevent further deterioration.” He only suggests that termination may prevent further deterioration (later on in life), and does not speculate as to whether early termination is protective against maternal death during a subsequent pregnancy.

In our opinion, the prognosis for maternal death seemed artificially inflated in the consensus statement. While it is possible that a patient with the reported clinical severity could present in the first trimester, from our analysis of the medical literature, this presentation seems rare. We believe that in most cases of PPCM, you could safely prolong pregnancy through viability and delivery of the child.

---


7 Ibid., 1633.
The consensus statement claims, "Moreover, the specific threat that arises from the presence of such hormones in a woman with peripartum cardiomyopathy subsides almost immediately once the placenta is separated from the uterus, or ‘deplanted,’ and the flow of hormones to the maternal system resulting from the interaction is completely stopped." The statement acknowledges that this action does not cure the heart, but eliminates the pathologic state that is a specific threat to the life of the mother and child. It is well documented that, in women who do not regain left ventricular function following the initial diagnosis of PPCM, death has occurred following either a termination or a delivery several years later without a subsequent pregnancy or even after a successful subsequent pregnancy.

In 2005, Elkayam et al. evaluated 123 women with a history of cardiomyopathy diagnosed during pregnancy or the postpartum period; no maternal deaths were reported during pregnancy. However, maternal deaths were reported at four months, seven months, one year, two years, three years, and nine years after delivery. In the eight cases of abortion in the Habli et al. study, five ended up on a heart transplantation list despite the early abortion. The authors of the consensus statement have no choice but to admit that there is always a pathologic state or specific threat that exists for the life of the patient.

This specific threat may never subside and certainly does not subside immediately after removal of the placenta. There is no evidence that either delivering at viability or performing an abortion prior to viability will mitigate or eliminate this pathology. This pathologic state exists regardless of whether or not the mother terminates. What is guaranteed, however, is the death of the child with each act of abortion. Termination comes with a false hope of “eliminating” the specific threat to the life of the mother and with a guarantee of death to the child.

Describing the interaction of the placenta with the ailing maternal heart as a "grave and present danger" is misleading. Describing the danger of maternal death as "present" implies that it can occur at any moment in the very near future (within days or weeks). As evidenced above, this is not the case, as maternal deaths have been reported years following the last pregnancy. 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. While the interaction may indeed be “grave,” there is no direct evidence to support that early termination mitigates the danger.

8 Colloquium, “Consensus Statement,” 482.
9 Uri Elkayam et al., “Pregnancy-Associated Cardiomyopathy: Clinical Characteristics and a Comparison between Early and Late Presentation,” Circulation 111.16 (April 26, 2005): 2050–2055.
In PPCM and pulmonary hypertension, the placenta and uterus are normal. If you compared the placenta from a woman with PPCM or pulmonary hypertension with the placenta from a woman in a normal and healthy pregnancy, there would be no difference; the trophoblastic tissue is normal. The placenta is physiologically normal and is producing hormones and other metabolites that act on maternal tissues. These placental products are necessary to sustain a normal physiologic pregnancy. Normal physiological changes include an increase in plasma and red blood cell volume, an increase in heart rate and ventricular compliance, and an increase in tidal volume of the lungs. Theoretically, if you could transfer the placenta from a patient with PPCM into the uterus of a woman who did not have a pathology of the heart or lungs, it would function normally and support the development of a normal fetus.

The underlying pathology in PPCM and pulmonary hypertension has nothing to do with the placenta; it is due to an underlying pathology in the lungs and heart. Therefore, abortion entails the removal of a normally functioning organ and, as a result, the direct death of the fetus. This action is equivalent to the removal of a healthy and normally functioning fetal heart. Essentially, you are removing a normally functioning and healthy organ from the fetus.

You could extend this argument to someone with pulmonary hypertension. The normal physiologic changes of pregnancy are acting on lungs that are diseased; this places the mother’s life in danger. Can the same argument justify an abortion? In fact, 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.

The placenta is derived from the single-celled embryo. This single-celled embryo is formed by the fusion of a single sperm with a single egg. All the cells of the fetus and placenta are derived from this original cell. Placental cells originate from the same original cell as do fetal kidney cells, cardiac cells, brain cells, and every other fetal cell. The placenta is an essential “organ” of the fetus; if removed, the fetus will perish as if you removed the fetal heart or any other integral organ necessary for fetal life. The placenta is a fetal organ derived from, and genetically identical to, the embryo.

The Abortive Act

During a labor induction abortion, the fetus is usually delivered prior to separation of the placenta from the uterus; this separation may occur up to thirty minutes after delivery of the fetus. Delay in placental separation from the uterus is more common at an early gestational age (less than twenty-four weeks’ gestation), when a


13 In contrast, Becket Gremmels et al. have argued that the placenta is “a quasi-substance that exists in symbiosis with mother and child.” See Gremmels et al., “The Metaphysical Status of the Placenta,” National Catholic Bioethics Quarterly 14.2 (Summer 2014): 295–333.
labor induction abortion would take place. If the abortion were performed in the first or early second trimester, it would most likely be accomplished by suction curettage; this would entail aspiration of the entire fetal–placental complex from the uterus.

In a second-trimester labor induction for abortive reasons, the fetus may die because of the forceful contractions of the uterus; this would occur long before separation of the placenta. In order for the consensus statement’s argument to be valid, one would have to be assured that the placenta would be removed first, leaving the fetus intact. This would ensure that the removal of the placenta, rather than the forceful contractions of the uterus, was what caused the death of the fetus. If the placenta is in situ while the fetus dies, then the action is directly on the fetus.

Ensuring the separation of the placenta from the uterus as the initial act of the abortion cannot be accomplished with any certainty. In a recent randomized trial comparing three different labor induction methods in women terminating for either a fetal abnormality or a maternal medical condition from fourteen to twenty-four weeks of pregnancy, the rates of retained placenta ranged from 18 to 20 percent. What this indicates is that the fetus was delivered and the placenta remained in situ. Thus, in one in five labor inductions, the fetus would die prior to delivery and the placenta would still be intact.

The case for double effect is usually made for cervical/uterine cancer during pregnancy. Here, however, the uterus is clearly pathologic and, if placed into another person, would remain pathologic. Microscopically, it would always reveal cancer. Removal of the diseased uterus by a hysterectomy is the recommended treatment. This is not analogous to PPCM, because the abortive act is not curative for the disease. In PPCM, women may still die from this disease several years after either an abortion or delivery. Most importantly, a hysterectomy to resolve uterine cancer is not a direct attack on the fetus.

**Analysis of Austriaco**

We believe a more coherent analysis exists. “Abortion in a Case of Pulmonary Arterial Hypertension,” by Rev. Nicanor Pier Giorgio Austriaco, OP, is a cogent, eloquent, and well-articulated analysis in the Thomistic commentatorial tradition that does not support abortion for pulmonary arterial hypertension, a serious maternal disease with very high mortality rates. The medical sequelae of pulmonary arterial hypertension parallel those of PPCM. Austriaco’s analysis concludes that “a physician who chooses to extract the placenta of an unborn child before viability is also necessarily choosing the death of the child as an object of his action. . . . By its very structure, the act of removing the placenta of an unborn child before viability is a direct attack upon the vital organs of the fetus.” We find it peculiar that the moral

---


15 Austriaco, “Abortion in a Case of Pulmonary Arterial Hypertension.”

16 Ibid., 509.
position that was so strongly defended in that precedent analysis was missing from
the consensus statement, especially since both claim adherence to the traditional
Thomistic action theory and moral framework. We are in agreement with the preced­
edent analysis by Austriaco.

The consensus statement sets a dangerous precedent; it neglects a more rigorous medical and ethical analysis and establishes a very low set-point. 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. In fact, we believe that if the position articulated in this consensus statement had been taken in the Phoenix case as discussed in the article by Austriaco (where the mother’s risk of mortality was close to 100 percent), that hospital would not have lost its Catholic charter.

We commend the authors of the consensus statement for taking on this difficult bioethical issue from a Catholic perspective. PPCM is a rare condition and a manifest threat to the life of the mother. It is not our intent to diminish the seriousness of this disease with respect to maternal mortality. We have presented these arguments to promote continued discussion and debate.