

Medical Intervention in Cases of Maternal–Fetal Vital Conflicts

A Statement of Consensus

A Colloquium Organized by Ascension Health

Abstract. This statement articulates a consensus of participants in a colloquium organized and sponsored by Ascension Health. The purpose was to consider what, if any, clinical interventions would be consistent with the Catholic moral tradition in the event that a woman's life is threatened because her body is unable to adapt to the changes associated with pregnancy because of a preexisting pathology. An example is peripartum cardiomyopathy in pregnancy. The consensus is offered for evaluating the morality of medical interventions in such cases and as the basis for developing clinical guidelines consistent with Catholic teaching and the standard of care. The colloquium participants agree that induction before viability to eliminate a grave and present danger posed by a life-threatening condition resulting from the interaction of a normally functioning placenta with diseased organs of the mother can be consistent with Catholic Church teaching and the moral tradition. *National Catholic Bioethics Quarterly* 14.3 (Autumn 2014): 477–489.

Background

1. This statement articulates the main conclusions and points of consensus reached by participants in a colloquium organized and sponsored by Ascension Health in St. Louis, Missouri, on October 15–16, 2013. The colloquium participants included ethicists, philosophers, theologians, scientists, and physician-specialists from both the Catholic health ministry and academia. They gathered to consider the question of what, if any, clinical interventions would be consistent with Catholic Church teaching and the Catholic moral tradition in cases in which a pregnant woman's life is threatened because her body is unable to adapt to the changes associated with pregnancy

owing to a preexisting pathologic condition. For the sake of procedural simplicity and clarity, a case of peripartum cardiomyopathy complicated by a subsequent pregnancy (PPCM+P) provided a paradigm case for consideration by the participants. The group examined questions about the development and relationship of the placenta to mother and baby, the pathophysiology of pregnancy-related diseases that affect hemodynamic systems (such as PPCM+P), methods for clinical interventions, the metaphysical status of the placenta, and moral methodology and relevant Church teaching.

The consensus articulated here is offered for consideration by ethicists, theologians, bishops, priests, clinicians, administrators, and lay persons when evaluating medical interventions in such cases and applying the teaching and moral tradition of the Catholic Church. 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.

Introduction

2. The following case served as an example for the colloquium participants to consider:

A twenty-three-year-old woman developed peripartum cardiomyopathy after her first pregnancy. This is a rare condition in which the walls of the heart are damaged so that the heart cannot pump blood effectively through the body. The condition develops during the peripartum period, during the last month of pregnancy or within several months after delivery, and its cause is unknown.

The patient was placed on standard medications to control the cardiomyopathy and was advised not to become pregnant again, since another pregnancy would exacerbate her condition and entail a significant risk of death.

The patient subsequently became pregnant, and had significant shortness of breath when seen by her obstetrician at six weeks' gestation. Her obstetrician referred her to a maternal–fetal medicine (MFM) specialist, who suggested adjustments in her medications. These changes successfully controlled her symptoms, and it was thought that the mother could safely carry the baby to viability if not to term.

To be safe, the MFM specialist referred the mother to a cardiologist, and she underwent a chemical stress test (dobutamine echocardiogram) to evaluate the ability of her heart to function under the strain of the progressing pregnancy. During the test, she experienced ventricular tachycardia (rapid heartbeat), shortness of breath, cardiac ischemia (restricted blood flow to the heart), and test intolerance such that she could not finish the test safely.

The test results confirmed the cardiomyopathy and showed that the mother's risk of death was greater than 93 percent.¹ The medical literature recommends terminating a pregnancy when the mortality risk is so high.

The patient sought a second opinion from three more cardiologists and one more MFM specialist. All agreed on the severity of her condition, and all agreed

¹ In the actual case on which this case is based, the mother's risk of mortality was about 50 percent, but we set a higher number here for the sake of argument.

that no treatment changes could improve her prognosis. All of her physicians concluded that an attempt to carry the pregnancy to viability would probably result in the mother's death as well as the death of the baby.

While the colloquium participants recognize that such cases will occur more frequently at facilities that are equipped to deal with high-risk pregnancies and have the necessary level of corresponding MFM capabilities, they also recognize that these cases can occur at any acute-care or emergency department and that the Catholic health ministry as a whole needs to be prepared to respond to them medically and morally in light of the inviolable dignity and right to life of both the mother and the unborn child.

Scientific and Medical Considerations

3. Peripartum cardiomyopathy is a relatively rare disorder “occurring at the end of the pregnancy or within 5 months after delivery without a pre-existing structural or functional heart disease.”² Risk factors include advanced maternal age, multiparity, multiple gestations, black race, obesity, malnutrition, gestational hypertension, pre-eclampsia, alcohol, cocaine and tobacco use, and low socioeconomic status.³ The pathophysiologic process involves inflammation in the heart that damages cardiac cells, causing cellular death or scarring. Since scarred muscle tissue cannot contract efficiently, the heart's ability to pump effectively decreases in proportion to any increase in scarred tissue. Consequently, the heart is unable to pump sufficient blood to meet the body's needs. This results in a backup of fluid in the lungs, causing shortness of breath and often swelling in the abdomen and extremities. Heart failure caused by peripartum cardiomyopathy presents a serious threat to a woman's life.⁴

4. For women with a history of peripartum cardiomyopathy, future pregnancies are potentially serious and possibly life threatening. Three main physiologic adaptations of pregnancy affect cardiac performance in patients with pre-existing cardiac disease, including peripartum cardiomyopathy: (1) increased heart rate, (2) increased cardiac output, and (3) reduced systemic vascular resistance, which is the amount of resistance posed by the circulatory system.⁵

Maternal cardiovascular adaptations begin early in pregnancy. The increase in blood volume is primarily due to the retention of sodium and water as the body attempts to maintain homeostasis, a stable inner environment. Maternal blood volume

² Melita Moioli et al., “Peripartum Cardiomyopathy,” *Archives of Gynecology and Obstetrics* 281.2 (February 2010): 183.

³ Pradipta Bhakta, Binay K. Biswas, and Basudeb Banerjee, “Peripartum Cardiomyopathy: Review of the Literature,” *Yonsei Medical Journal* 48.5 (October 31, 2007): 732.

⁴ The mortality rate, in general, is 25 to 50 percent for the most serious cases (New York Heart Association class 4). Patients whose left ventricular dilation resolves within six months after pregnancy (50 percent) have a good prognosis.

⁵ Thomas R. Easterling and Karen Stout, “Heart Disease,” in *Obstetrics: Normal and Problem Pregnancies*, 5th ed., ed. Steven Gabbe, Jennifer Niebyl, and Joe Simpson (Philadelphia: Churchill Livingstone, 2007), 915.

increases, on average, by more than 10 percent by 8 weeks' gestation⁶ and, at term, by 45 to 50 percent in singleton pregnancies and more in multifetal pregnancies.⁷ Similarly, the rise in maternal cardiac output, a function of increased heart rate and increased cardiac stroke volume related to the reduced systemic vascular resistance,⁸ begins early in pregnancy. Cardiac output rises 10 percent by five weeks' gestation,⁹ around 25 percent by eight weeks' gestation,¹⁰ and 34 percent by twelve weeks' gestation, "accounting for about 75 percent of the total increase in cardiac output during pregnancy."¹¹ At term, cardiac output is 30 to 50 percent above nonpregnant levels.¹²

5. Most patients with a history of peripartum cardiomyopathy who become pregnant have sufficient cardiac reserve to handle the additional cardiac burdens posed by pregnancy and can be safely managed until fetal viability or even term. Unfortunately, the prognosis is worse for patients with residual left ventricular dysfunction. Even patients with normalization of left ventricular function are at risk for recurrent peripartum cardiomyopathy if they become pregnant again.¹³

⁶ F. Gary Cunningham et al., *Williams Obstetrics*, 23rd ed. (New York: McGraw-Hill, 2010), chap. 5., "Maternal Physiology," under the heading "Hematological Changes," esp. fig. 5-5.

⁷ Edward K. S. Chien and Helen Feltovich, "Maternal, Biological, Biomechanical, and Biochemical Changes in Pregnancy," in *Clinical Obstetrics*, 3rd ed., ed. E. Albert Reece and John C. Hobbins (Malden, MA: Blackwell, 2007), 636; Manju Monga, "Maternal Cardiovascular, Respiratory, and Renal Adaptation to Pregnancy," in *Creasy and Resnik's Maternal-Fetal Medicine: Principles and Practice*, 5th ed., ed. Robert Creasy et al. (Philadelphia: Saunders, 2008), 111; and Easterling and Stout, "Heart Disease," 915.

⁸ Cunningham et al., *Williams Obstetrics*, chap. 5.

⁹ *Ibid.*, chaps. 5 and 44; and Michael C. Gordon, "Maternal Physiology," in *Obstetrics*, ed. Gabbe et al., 59.

¹⁰ Manju Monga, "Maternal Cardiovascular, Respiratory, and Renal Adaptation to Pregnancy," 112.

¹¹ Gordon, "Maternal Physiology," 59.

¹² Chien and Feltovich, "Maternal, Biological, Biomechanical, and Biochemical Changes in Pregnancy," 633; and Gordon, "Maternal Physiology," 58.

¹³ Easterling and Stout, "Heart Disease," 929. This is especially true of those patients with an ejection fraction of less than 50 percent (the percentage of blood pumped out of the ventricles with each beat); see Cunningham et al., *Williams Obstetrics*, chap. 44, "Cardiovascular Disease," under the heading "Other Cardiovascular Conditions, Peripartum Cardiomyopathy"; and Creasy et al., *Maternal-Fetal Medicine*, 798. One study followed sixty-seven pregnancies in sixty-three women with PPCM. Of the forty-three pregnancies in those with normalized left ventricular function postpartum, ten were associated with cardiac dysfunction in a subsequent pregnancy and one woman died. Of the twenty-four pregnancies in women who continued to have left ventricular dysfunction postpartum, thirteen were associated with dysfunction in a subsequent pregnancy and two women died. See Uri Elkayam et al., "Maternal and Fetal Outcomes of Subsequent Pregnancies in Women with Peripartum Cardiomyopathy," *New England Journal of Medicine* 344.21 (May 24, 2001): 1570.

In a subsequent pregnancy, the patient's left ventricular function at her initial presentation is the most important factor that is predictive of mortality.¹⁴ Typically, the patient undergoes a chemical stress test—a dobutamine stress echocardiogram—to assess left ventricular function and cardiac reserve.¹⁵ The stress test places strains on the heart that are similar to the strains that occur in advanced pregnancy.¹⁶ If the patient is able to tolerate the test without significantly impaired heart function, then she is likely to do well during the pregnancy, assuming close follow-up and good medical management. However, if her heart is not able to endure the stress test and she begins to develop heart failure or impaired cardiac function, then she is unlikely to tolerate the increased circulatory stress of the progressing pregnancy.

6. Normal functioning of the placenta enables the mother to adapt to the demands of pregnancy and support the child's life before, during, and after birth. One of the endocrine functions of the placenta is to produce a number of hormones (e.g., estrogen, progesterone, atrial natriuretic peptide, brain natriuretic peptide, and others) that lead to maternal retention of sodium and fluid and increase maternal blood volumes. The placenta produces these hormones to act together and independently to regulate the volume of intracellular and extracellular fluid in the mother's body. In cases of PPCM+P, it is the interaction of these hormones together that has a direct adverse effect on the mother's cardiac function.¹⁷ In such cases, severe fluid retention due to excess sodium retention can lead to pulmonary edema and to combined respiratory and cardiac failure, which can be fatal in advanced cases.

7. Although rare, PPCM+P presents a unique threat to the life of the mother, one that is not caused simply by the mother's weakened heart (i.e., by peripartum cardiomyopathy as a pre-existing condition). Rather, in PPCM+P it is the interaction of a normal functioning placenta (as it produces hormones that increase sodium and fluid retention and blood volumes to support both the mother and the fetus through pregnancy) with the mother's weakened heart that engenders the specific threat to her life and that of her pre-viable child. This specific threat is not present when the

¹⁴ John Abboud et al., "Peripartum Cardiomyopathy: A Comprehensive Review," *International Journal of Cardiology* 118.3 (June 12, 2007): 300; Karen Sliwa, James Fett, and Uri Elkayam, "Peripartum Cardiomyopathy," *Lancet* 368.9536 (August 19, 2006): 691; and Moioli et al., "Peripartum Cardiomyopathy," 186.

¹⁵ Sharmila Dorbala et al., "Risk Stratification of Women with Peripartum Cardiomyopathy at Initial Presentation: A Dobutamine Stress Echocardiography Study," *Journal of the American Society of Echocardiography* 18.1 (January 2005): 45–48.

¹⁶ Mark B. Lampert et al., "Contractile Reserve in Patients with Peripartum Cardiomyopathy and Recovered Left Ventricular Function," *American Journal of Obstetrics and Gynecology* 176.1, part 1 (January 1997): 189–195.

¹⁷ Cardiac output is a measure of the work done by the heart based on how much blood flows through it. It is calculated by multiplying the heart rate by the stroke volume (the volume of blood pumped from the heart with each beat). Cardiac output increases significantly in a normal pregnancy and is deleteriously reduced by PPCM because of complex hormonal and physiologic changes. Notice too that what is called the trophoblast at earlier gestational ages will develop into the placenta as the pregnancy progresses. For clarity, therefore, only the term "placenta" is used here.

placenta-derived hormones are not present. 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.

Such an intervention of placental deplantaion does not cure the mother’s weakened heart—there is no current cure for such organ damage—but it *does* eliminate the pathological state that is a specific threat to the life of the mother and the child that arises directly from the interaction of the placenta and the diseased heart in PPCM+P. The fact that deplantaion truly eliminates the threat to the mother’s life arising from the hormonal interaction is particularly evident when it is recognized that the patient in the case described here had no threat to her life before pregnancy owing to the appropriate use of her cardiac medications. If it were not for the interaction of the placenta with the mother’s diseased heart, her life would not be in danger. Of course, the concomitant effect of deplantaion of the placenta is the subsequent but unavoidable death of the child if the deplantaion occurs before viability.

Ethical and Theological Considerations

8. Maternal–fetal vital conflicts can be described as clinical situations in which state-of-the-art medicine presents only one of two foreseeable outcomes: (1) without medical intervention, both mother and child will die, or (2) with intervention, the mother alone can be saved. Because of the inviolable human dignity of both mother and child, maternal–fetal vital conflicts present Catholic medical providers with practical challenges in determining the morally appropriate means of intervention—namely, means that respect the life and dignity of *both* mother and child in these tragic circumstances.

9. The *Catechism of the Catholic Church* articulates Church teaching on the dignity of human life: “Every human life, from the moment of conception until death, is sacred because the human person has been willed for its own sake in the image and likeness of the living and holy God” (n. 2319). In light of this inherent dignity, bestowed on every human life and most fully revealed in the person of Jesus Christ, the Church has taught with enduring consistency the grave immorality of procured or direct abortion, which is abortion “willed as an end or as a means.”¹⁸ In this context, official Church teaching defines abortion as “the deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to birth.”¹⁹ In his encyclical letter *Evangelium vitae*, Pope St. John Paul II quotes from the earliest known Christian document that touches on abortion, the *Didache*, or *Teaching of the Twelve Apostles*, from the first century: “There are two ways, a way of life and a way of death; there

¹⁸ John Paul II, *Evangelium vitae*, The Gospel of Life (March 25, 1995), n. 62; see also *Catechism*, n. 2271.

¹⁹ *Ibid.*, n. 58, quoted in Congregation for the Doctrine of the Faith, *Dignitas personae*, On Certain Bioethical Questions (September 8, 2008), n. 23.

is a great difference between them.” To avoid the way of death, the *Didache* commands, “You shall not put a child to death by abortion nor kill it once it is born.”²⁰

10. Historically, as John Connery notes, some Catholic moral theologians in good standing with the magisterium have held that terminating a pregnancy before viability as part of an attempt to address a pre-existing and independently originating pathological condition threatening the mother’s life, such as PPCM+P, necessarily entails a direct assault on the unborn baby, regardless of the means used.²¹ According to this understanding, the death of the fetus is directly willed by the physician as a means to treat the mother’s medical condition, and the death is immediately caused by the surgical instrument under the physician’s control, while the improved functioning of the mother’s organs, which effectively saves her life, is merely an indirect effect of the same action. Thus, according to this understanding, taking the life of the fetus is the directly intended means by which the strain on the maternal organs is reduced.

Yet the preceding considerations of the pathophysiology of PPCM+P (in paragraphs 3–7 above) and similar conditions give us reason to re-examine the relationship between the good effect (the reduced strain on the maternal heart) and the bad effect (the death of the unborn child) within the framework of and consistent with the focus on the moral species of both the ends and the means within the Catholic natural law framework of moral reasoning.

11. While alternative methods for morally analyzing cases of maternal–fetal vital conflict have been proposed,²² the participants in this colloquium agreed that the traditional Thomistic action-theory and moral framework as it is articulated in magisterial teachings, such as the Catechism and John Paul II’s encyclical *Veritatis splendor*, provide the appropriate methodological framework for analyzing the moral

²⁰ John Paul II, *Evangelium vitae*, n. 54, quoting *Didache*, 1.1 and 2.1–2.

²¹ John R. Connery, *Abortion: The Development of the Roman Catholic Perspective* (Chicago: Loyola University Press, 1977), 287–288. See also Committee on Doctrine, US Conference of Catholic Bishops, “The Distinction between Direct Abortion and Legitimate Medical Procedures” (June 10, 2010), available at <http://www.ncpd.org/sites/default/files/direct-abortion-statement2010-06-23.pdf>. For a summary of the historical development of the teaching on vital conflicts, see David Albert Jones, “Magisterial Teaching on Vital Conflicts: A Reply to Rev. Kevin Flannery, SJ,” *National Catholic Bioethics Quarterly* 14.1 (Spring 2014): 81–104.

²² See, for example, Martin Rhonheimer, *Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancies*, trans. William F. Murphy (Washington, DC: Catholic University of America Press, 2009); M. Therese Lysaught, “Moral Analysis of Procedure at Phoenix Hospital,” *Origins* 40.33 (January 27, 2011): 537–547; Gerald Magill, “Threat of Imminent Death in Pregnancy: A Role for Double-Effect Reasoning,” *Theological Studies* 72.4 (December 2011): 848–878; Daniel C. McGuire and James T. Burtchaell, “The Catholic Legacy and Abortion: A Debate,” *Commonweal* 126 (November 20, 1987): 657–672; and Germain Grisez, *Abortion: The Myths, the Realities, and the Arguments* (New York: Corpus, 1970), 334–346.

status of interventions in cases of PPCM+P in a manner consistent with the Catholic moral tradition.²³

12. More specifically, the principle of double effect, as it has been taught in the Catholic moral tradition, provides the appropriate framework of moral reasoning to assess the moral status of interventions in PPCM+P. The principle of double effect identifies four criteria for evaluating the moral status of a proposed action that will have a good effect and a bad effect, both of which are foreseen by the moral agent:

- i. The rationally chosen object of the act must be good, or at least morally neutral. (The object concerns the proximate end of the will.)²⁴
- ii. The agent must directly intend only the good effect and not the bad effect. (The intention concerns the ultimate or remote end of the acting subject, which may or may not also coincide with the object or proximate end.)²⁵
- iii. The good effect cannot be achieved by means of the bad effect.
- iv. The good effect must be proportionate to the bad effect, with no better alternative possible.

Only if all these conditions are met can a proposed act that has both a good and a bad effect be morally justified.²⁶

13. Directive 45 of the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)* summarizes the Church's teaching on abortion as it applies to Catholic health care institutions: "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, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation."²⁷ Thus, interventions for PPCM+P in which the death of the child is either the chosen end or means by which the good effect is brought about (caused) would be contrary to directive 45 and therefore illicit in Catholic hospitals.

14. Directive 47 of the *ERDs* states, "Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological

²³ See *Catechism*, nn. 1749–1761; and John Paul II, *Veritatis splendor*, The Splendor of Truth (Boston: St. Paul Books and Media, 1993), nn. 72–83.

²⁴ See *Catechism*, nn. 1751, 1755, and 1756.

²⁵ See Thomas Aquinas, *Summa theologiae (ST)* I-II, q. 20, a. 3, and q. 1, a. 3. See also *Catechism*, nn. 1751–1753; and Ralph McInerny, *Aquinas on Human Action: A Theory of Practice* (Washington, DC: Catholic University of America Press, 2012), 81–83.

²⁶ See *Catechism*, nn. 1750–1761; Joseph T. Mangan, "An Historical Analysis of the Principle of Double Effect," *Theological Studies* 10.1 (1949): 41–61; and Peter J. Cataldo, "The Principle of Double Effect," in *Ethical Principle in Catholic Health Care: Selections from 25 Years of Ethics & Medics*, ed. Edward James Furton (Boston: National Catholic Bioethics Center, 1999), 81–84.

²⁷ US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), n. 45.

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.”²⁸ This seems to be an appeal to the principle of double effect. Thus, interventions for PPCM+P in which the death of the child is not the chosen end or the means for causing the good effect of saving the mother’s life, but is rather a foreseen but unintended side effect of an action that of itself is immediately directed at curing the mother, would be consistent with directive 47 and therefore permissible.

15. Since the child’s death (as just described in paragraph 14) is neither the remote nor the proximate end of the agent’s act, and since deplating the placenta from the uterus (as described in paragraph 7) to stop the harmful influence of the placental hormones on maternal cardiac function—a good and desirable effect—will also have the effect of the child’s death, it is imperative to determine whether interventions into PPCM+P that result in the deplating of the placenta from the uterus fall under directive 45 or directive 47. In other words, it must be determined whether the death of the child is the rationally chosen object of the act, deliberately willed in order to remove the threat of PPCM+P to the mother’s life, or whether the child’s death is a foreseen but unintended side effect of a treatment that removes the threat to the mother’s life.

Points of Consensus

16. Interventions that surgically dismember a live fetus in order to remove it from the uterus are impermissible under Church teaching and directive 45 by reason of the very object of the act, in which the death of the child is deliberately willed in order to remove the threat to the mother.

17. Interventions that involve the medical induction of labor following viability to alleviate a proportionately serious threat to the mother’s life are consistent with directive 49: “For a proportionate reason, labor may be induced after the fetus is viable.” Prior to fetal viability, similar interventions may be consistent with directive 47. The presence of fetal heart tones does not automatically preclude medical induction, which is justified for a number of medical conditions, for example, chorioamnionitis in the setting of preterm premature rupture of membranes, pre-eclampsia, and augmentation of labor to save a mother’s life.²⁹

²⁸ Ibid., n. 47.

²⁹ National Catholic Bioethics Center, *Statement on Early Induction of Labor*, March 11, 2004, http://www.ncpd.org/sites/default/files/NCBC_STATEMENT_ON_EARLY_INDUCTION_OF_LABOR_March_11.pdf; Jean deBlois and Kevin D. O’Rourke, “Care for the Beginning of Life: The Revised Ethical and Religious Directives Discuss Abortion, Contraception, and Assisted Reproduction,” *Health Progress* 76.7 (September–October 1995): 39; Ron Hamel, “Managing Abnormal Pregnancies Prior to Viability,” *Health Care Ethics USA* 17.2 (Spring 2009): 10; Peter J. Cataldo and T. Murphy Goodwin, “Early Induction of Labor,” *Catholic Health Care Ethics: A Manual for Ethics Committees* (Philadelphia: National Catholic Bioethics Center, 2009), 113; and Ron Hamel, “Early Pregnancy Complications and the Ethical and Religious Directives,” *Health Progress* 93.3 (May–June 2014): 54–55.

18. The principle of double effect is morally appropriate for the full evaluation of the proposed induction of labor to deplant the placenta in cases of maternal–fetal vital conflict similar to those of PPCM+P, in which it is the pathological interaction of the normal functioning placenta with the mother’s weakened heart that gives rise to the specific threat to the mother’s life. In such cases, it is necessary to determine whether the act of causing deplantation of the healthy, normally functioning placenta by triggering the uterus to contract is morally good, morally neutral, or intrinsically immoral (by reason of its object).³⁰

19. Medical induction of labor prior to fetal viability to eliminate a grave and present danger posed by the interaction of the normally functioning placenta with the weakened heart of the mother can be consistent with directive 47 and justified in accord with the principle of double effect. The exterior act is described as the medical induction of labor prior to fetal viability by triggering the uterus to contract. The two effects of this act are

- The elimination of a threat to the life of the mother and the child caused by the placenta’s interaction with the weakened heart of the mother—the good effect
- The death of the child (fetus)—the bad effect

The medical induction of labor by triggering the uterus to contract prior to fetal viability to eliminate a grave and present danger posed by the placenta’s pathology-inducing interaction with the weakened heart of the mother satisfies the conditions of the principle of double effect:

- i. The moral object or proximate end of the act—which is 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—is good or at least morally neutral.³¹
- ii. The remote end of the act—which is to eliminate the *grave and present danger* by deplanting the placenta from the uterus in order to save the mother’s life—is the intended good effect; the death of the child is the foreseen but unintended bad effect.
- iii. The elimination of the grave and present danger is not caused by the death of the child.

³⁰ The Catechism distinguishes among object, intention, and circumstances (nn. 1751–1754). The rationally chosen object of the act is described as the good—the “matter” of the act—which morally specifies the act of the will (i.e., the exterior act of the will). The intention concerns itself with the goal of the acting subject (i.e., the interior act of the will), which may or may not coincide with the object. One and the same action can be inspired by several intentions. Circumstances “contribute to increasing or diminishing the moral goodness or evil of human acts,” but “circumstances of themselves cannot change the moral quality of acts themselves; they can make neither good nor right an action that is in itself evil” (n. 1754). See also *ST I-II*, q. 18, a. 6.

³¹ At the least it is not intrinsically evil, as it is justified to induce labor before viability in other instances, like those described above in paragraph 18.

- iv. The foreseen but unintended death of the child is proportionate to saving the life of the mother.

The group reached a consensus that the mother need not be immediately and imminently dying, but that one need only to foresee with moral certitude that without medical intervention, there is a grave and present danger of death to the mother and child. There was also consensus that moral certitude does not require *absolute* certainty, but that the best available clinical evidence and reasonable medical judgment³² indicate that, if allowed to progress, the condition will lead to the death of both the mother and the fetus prior to viability. Pope Pius XII describes moral certitude as characterized “on the positive side by the exclusion of well-founded or reasonable doubt,” and “on the negative side, it does admit the absolute possibility of the contrary.”³³

20. This analysis represents what the colloquium participants consider a legitimate understanding of the way “the cure of a proportionately serious pathological condition” in directive 47 can be interpreted and applied. The authors believe it to be inclusive of *but not limited to* the cure of an underlying pathological condition associated directly with a diseased organ, such as heart failure. The colloquium participants agree that a “pathological condition” is better understood in the way Pius XII used it, to represent not only a diseased organ but any present and grave threat to a person’s life. In fact, as Pius XII (1953) and the moral tradition going back to Juan de Lugo (1642) confirm, it is the danger factor that is morally decisive.³⁴ It is the desire to eliminate or diminish the danger that is the condition for action. Such a danger may be caused by *either* a diseased or a healthy organ. Thus, intervening to eliminate the threat to a person’s life, even if it does not eliminate a persistent underlying pathological condition, can be sufficient to satisfy the moral criteria of curing “a proportionately serious pathological condition,” *so long as the means, that is, the chosen object of the act, does not itself constitute a direct attack against human life, and so long as the bad effect is not what is intended*. This is particularly relevant in cases of maternal–fetal vital conflict in which the threat arises not from a particular organ but from the interaction of healthy organs and non-healthy organs or from the normal functioning of an organ that exacerbates or causes the condition that threatens

³² Such knowledge is always imperfect, especially if we account for the concrete circumstances of the clinical capacity of the facility, and the availability or nonavailability of a specialist in maternal–fetal medicine.

³³ Pius XII, Allocation to Rota (October 1, 1942), n. 1, in *The Canon Law Digest*, vol. 3, 1942–1953, ed. T. Lincoln Bouscaren (Milwaukee, WI: Bruce Publishing, 1954), 607.

³⁴ Pius XII, “Removal of a Healthy Organ,” Allocation to Delegates at the Twenty-Sixth Congress of Urology (October 8, 1953), in *The Human Body: Papal Teachings*, ed. Monks of Solesmes (Boston: Daughters of St. Paul, 1960), 277–279, and “Christian Principles and the Medical Profession,” Allocation to the Italian Medical-Biological Union of St. Luke (November 12, 1944), in *Human Body*, 55. See also Kevin O’Rourke and Philip Boyle, *Medical Ethics: Sources of Catholic Teachings, Second Edition* (Washington, DC: Georgetown University Press, 1993), 320–321; and Gerald Kelly, “The Morality of Mutilation: Towards a Revision of the Treatise,” *Theological Studies* 17.3 (September 1956): 336, referencing Juan de Lugo, *De justitia et jure* (1642), disp. 10, n. 22.

the lives of both the mother and the unborn child. The participants agree that this interpretation and application of directive 47 is consistent with the Catholic moral tradition and with Church teaching, especially as it is articulated in the magisterium of Pius XII, but also that such an interpretation is ultimately subject to the review of the appropriate ecclesial authority, that is, the magisterium.

Conclusion

21. After thoroughly and prayerfully examining the medical, scientific, philosophical, moral theological, and magisterial dimensions of this serious matter, the participants in this colloquium agree 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, with Church teaching, and with the Catholic moral tradition. In light of human limitations and the limitations of medical science, Christ calls his Church to heal the sick and manifest his loving presence in the world, especially to those who are most vulnerable. Patients suffering with PPCM+P, both mother and child, are some of the most vulnerable persons served by the Catholic health ministry. Hence, Catholic health care maintains a special responsibility to care for each and to manifest God's love for each by intervening in such tragic circumstances in a manner that affirms the irreducible dignity of both.

July 19, 2014

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