THE NATIONAL CATHOLIC BIOETHICS CENTER

EARLY INDUCTION OF LABOR

PREPARED BY THE ETHICISTS OF THE NCBC
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"Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child. … For a proportionate reason, labor may be induced after the fetus is viable." —
USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (2009), nn. 47, 49.

❖ SUMMARY ❖

• In most developed countries, the earliest gestational age for fetal viability is twenty-three weeks. About 17 percent of children born at this age survive, many with major disabilities. • In every pregnancy, there are two interdependent patients, mother and fetus, and their interests sometimes conflict. When such a conflict occurs after fetal viability, the burdens associated with continuing the pregnancy compared to the burdens of early induction of labor must be carefully weighed for each patient in an attempt to achieve the best clinical outcomes for both. • In some cases, early induction after viability may give a baby a chance to live. In fetal hemolytic disease, for example, incompatibility between maternal and fetal blood means that the baby is likely to die if the pregnancy continues, even though the mother remains largely unaffected. • In certain severe cases, the principle of double effect may allow for early induction of labor before viability, where the premature birth or the demise of the baby is foreseen but unintended.

Examples of Morally Acceptable Grounds (Proportionate Reasons) for Early Induction of Labor

Serious intractable maternal illness may be caused by the pregnancy itself, as when a pathology arises from the placenta or in infected membrances, which will need to be delivered if the mother is to survive. This may occur, for example, in cases of pre-eclampsia or HELLP (hemolysis, elevated liver enzymes, and low platelet count) syndrome. Also, intrauterine infection (chorioamnionitis) to expel infected membrances may occur after preterm premature rupture of membranes. Such a case is usually treated with expectant management—that is, the mother is given antibiotics and steroids and closely monitored. Early induction of labor to expel infected membranes may be justified if evidence arises of a significant risk to the mother's life.

Examples of Morally Unacceptable Grounds (Disproportionate Reasons) for Early Induction of Labor

• The presence of fetal anomalies does not in itself justify early induction of labor. Lethal anomalies include anencephaly, some cases of trisomy 18 (Edwards syndrome), and trisomy 13 (Patau syndrome); nonlethal but seriously disabling anomalies include trisomy 21 (Down syndrome) and neural tube defects. Early induction after viability may be performed for a proportionate reason, such as a need to manage the delivery medically. • Emotional distress to the mother from the pregnancy does not justify early induction of labor. The death of the baby is not a treatment for the mother's emotional distress and cannot be justified.

An Example of Controversial Grounds

A woman with severe heart or pulmonary disease may not be able to tolerate the added stress of increased blood volume from normal placental blood flow during pregnancy. It is unclear whether she may undergo an early induction. Although the placenta causes the increased blood volume in the mother, this is a normal part of pregnancy, not a pathological condition per se. The weakness of the mother's heart or lungs is not directly remediated by early induction, so there is significant doubt as to whether the principle of double effect can be validly applied in this case.

❖ FAQ ❖

Question 1. What is viability?

Reply: Viability is the ability of a neonate to survive outside the womb, even when survival requires the use of life-sustaining technology. In most industrial countries, fetal viability occurs at a gestational age of about twenty-three weeks and a fetal weight of at least 400 g (14.1 oz).

Early induction performed before viability necessarily causes the death of the baby and may be performed only in the gravest circumstances. When early induction is performed after viability, the baby has some chance of surviving. (Survival of babies born at twenty-three weeks' gestation is about 17 percent, and many survivors have major disabilities.)

Question 2. When may early induction be permitted?

Reply: Any act that directly causes or hastens the death of the child is forbidden. Early induction before viability can occasionally be justified in very grave circumstances, however. To evaluate this, we assess each case using the four conditions of the principle of double effect. All four conditions must be met for early induction to be permitted: (1) The act itself constitutes a good or is morally neutral; that is, early induction is performed to directly treat a very serious threat to the mother's life (e.g., expel infected membranes). (2) The good effect (treating the pathology of the mother) is intended, and the bad effect (the death of the baby), while foreseen, is not intended. (3) The baby's death is not the means by which the mother's disease is treated. And (4) the good of saving the mother's life is proportionate to the bad effect (that is, the death of both mother and baby), and no other reasonable alternative is available.

These conditions are sometimes met in cases where the threat to the mother's life is caused not by the baby but by intrauterine infection or disease of the placenta, as in chorioamnionitis, pre-eclampsia, or HELLP syndrome. In such cases, early induction may be justified to remove the pathologic tissues. The baby's death is foreseen but not intended.

Early induction after viability, when the baby has a chance of living, can be performed only for reasons proportionate to the risks, as when the delivery needs to be performed immediately to safeguard the health of the mother or child.

Question 3. Why isn't early induction (or termination by other means) permitted in cases where the baby has anomalies and the mother is emotionally distressed by the pregnancy?

Reply: Any method of terminating a pregnancy for the purpose of causing the death of the baby by prematurity or that constitutes a direct attack on the fetus—a dilation-and-curettage (D&C) or dilation-and-extraction (D&E) procedure, for example—is never permitted.

A procedure that causes the baby's death in order to spare the mother's feelings can never be justified. In terms of the principle of double effect, the baby's death constitutes the means by which the mother's feelings temporarily are spared, which violates the third condition.

Question 4. Can the principle of double effect be used to justify the termination of a pregnancy in the case of a woman with severe cardiac or pulmonary disease, who may not be able to tolerate the added stress of increased blood volume from normal placental blood flow during pregnancy?

Reply: Some say it can, but to others the principle of double effect cannot be applied in such a case, since early induction is being used to terminate a normal pregnancy, not to treat the condition causing the problem—that is, the mother's weakened heart or lungs. Early induction in such a case appears to be simply a lethal attack on the baby for the purpose of removing the strain of the pregnancy on the mother, which cannot be justified.

❖ Resources ❖

Monica Rafie and Tracy Winsor, "Hope after Poor Prenatal Diagnosis: A Catholic Response," *Ethics & Medics* 36.10 (October 2011): 1–4. Reproduced by permission.

Nancy Valko, "The Case against Premature Induction: Mothers, Children, and Anencephaly," *Ethics & Medics* 29.5 (May 2004): 1–2. Reproduced by permission.

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