ETHICS & MEDICS
A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences
AUGUST 2022 VOLUME 47, NUMBER 8

Medical Interventions During Pregnancy in Light of Dobbs

John A. Di Camillo and Jozef D. Zalot

In the wake of the US Supreme Court's ruling in *Dobbs v. Jackson Woman's Health*, abortion supporters—including the Biden administration—are claiming that women experiencing serious pregnancy-related and perinatal complications will be refused treatment by Catholic institutions and clinicians.[1] These claims arise from the perception that the Catholic Church does not allow medical interventions to treat a pregnant woman if the intervention results in significant harm to—or even the death of—her unborn child. This perception is incorrect. Catholic health care can and should treat a pregnant woman who is diagnosed with a pathological condition "in a manner consonant with its mission" (ERD 44).

This brief resource summarizes the NCBC's existing guidance on how complicated pregnancies that threaten the life of the mother can be treated in accord with Catholic moral teaching,[2] particularly as found in the United States Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), 6th edition (2018).[3] This guidance is general in nature, but each medical situation is unique. As such, one must apply the appropriate ethical principles and Church teaching(s) to the particular case in question. For further assistance with applying this guidance, please contact the NCBC.

Life-Saving Medical Interventions and Pregnancy

The teaching of the Catholic Church and the practice of Catholic health care are centered on caring for both the pregnant woman and her unborn child. They are two distinct human beings and therefore two patients. In situations involving a threat to the mother's health or life, Pope Pius XI summarized Church teaching by stating: "Upright and skillful doctors strive most praiseworthily to guard and preserve the lives of both mother and child; on the contrary, those show themselves most unworthy of the noble medical profession who encompass the death of one or the other, through a pretense at practicing medicine or through motives of misguided pity."[4] Thus, according to Pius XI, physicians have a duty to treat both mother and child, and it is never legitimate to deliberately kill the unborn child, even if the goal is to save the mother's life.

There are, however, situations where a medical intervention to treat the mother can be legitimate even though it will adversely affect the unborn child, possibly even resulting in the child's death. One example is when a pregnant woman is diagnosed with an aggressive form of uterine cancer requiring immediate intervention prior to fetal viability. The Church's guidance in these situations is stated in Directives 45 and 47 of the ERDs.

> Directive 45: "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 …"
>
> Directive 47: "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."

As the unborn child is fully a human being deserving of dignity and respect, the Catholic Church teaches that direct abortion is never permissible. However, in the absence of better, reasonable alternatives that would preserve the life of the child, a pregnant woman may be treated for a life-threatening condition through an appropriate medical intervention even if a foreknown but unintended consequence of the intervention is the death of her unborn child.[5] In the example above, it could be permissible for the woman to undergo a hysterectomy if this were the medically indicated treatment for the uterine cancer. Certainly, this would be a difficult decision for the mother to make because it results in the loss of her child. But such an intervention can be permissible in accord with the principle of double effect, a philosophical principle that can be applied when each of its four conditions is satisfied:[6]

1. The intervention itself is morally good; in this case, hysterectomy is the appropriate medical intervention that directly addresses the mother's uterine cancer.
2. The intent of the intervention is the mother's healing, which is the good effect, and not the death of the unborn child; the hysterectomy is performed to cure the woman of the cancer, not to end the life of her unborn child.
3. The death of the child, which is the bad effect, is not the means by which the mother is healed. The child's death is not what removes the cancer from the woman's body; the hysterectomy does.
4. There exists a proportionately serious reason to proceed with the intervention despite the undesired outcome of the death of the unborn child; in this case, the preservation of the mother's life in the absence of reasonable alternatives could be a proportionately serious reason.

It is important to note that the principle of double effect does not require the woman to undergo an intervention for her pathological condition that will indirectly result in the death of her unborn child. Following proper informed consent, she may decline the medical intervention(s) presented to her in hopes of allowing her child to reach viability or beyond. St. Gianna Molla is well-known for declining treatment in a similar situation so as not to harm her unborn child. In these cases, all other measures to support both the mother and unborn child should be made available.

Regardless of what a mother chooses, pastoral care should be made available for the woman herself, the father, loved ones, and the medical staff.

Early Delivery

One lifesaving medical intervention related to pregnancy that deserves special attention is early delivery. Attempting to carry a pregnancy to term may, in certain cases, seriously jeopardize the mother's life. Examples of medical conditions that can threaten her life include pre-eclampsia, HELLP (hemolysis, elevated liver enzymes, and low platelet count) syndrome, or chorioamnionitis (intrauterine infection) following preterm premature rupture of membranes (PPROM). These cases are usually treated initially with expectant management—that is, the mother is given appropriate medications and is closely monitored. However, these cases can progress (sometimes quickly) to a point where early delivery of the child may become medically indicated.

In discussing these and similar cases from a Catholic moral standpoint, however, a distinction must be made between post-viability and pre-viability delivery. Catholic teaching and the ERDs are very clear regarding the general legitimacy of post-viability delivery by induction or Caesarean section, whereby the health and life of both the mother and the child can be preserved. They are less clear with regard to inducing labor prior to viability.

Post-Viability Induction

Catholic teaching maintains that if a proportionate medical reason exits, post-viability induction is morally permissible (ERD 49). This is clear and consistent through all prior versions of the ERDs and finds explicit and authoritative confirmation from as far back as a reply of the Holy Office in 1898.[7] It is important to note, however, that the ERDs do not offer specific criteria of what constitutes "a proportionate medical reason." The NCBC has maintained that three important factors must be considered in discerning the permissibility of such induction.

First, as both the mother and child are patients, indicators of induction should focus on the *physical* life and health of both mother and child. For example, early induction of labor after viability may be performed if a life-threatening condition arises with either the mother or the child. It could also be performed in situations of a life-limiting fetal condition if it will benefit the child.

Second, indicators of induction generally should not focus on psychological factors. For example, induction generally would not be permissible if done to address the mother's emotional distress regarding the life-limiting condition of the child while providing no medical benefit to the child.[8] In addition, the mother's preference alone (desired birth date, etc.) does not constitute a proportionately serious reason to induce labor after viability, particularly if doing so would pose additional risk to the child's health or life.

Third, every effort should be made to help assure the survival of the child post-induction. This includes treatment prior to induction, when appropriate, as well as providing the standard of care associated with prematurity following induction, including stabilization and evaluation.

Pre-Viability Induction of Labor

The Catholic Church has grappled for centuries with the distinction between direct abortion and legitimate maternal interventions that may result in the child's death prior to viability. An intense debate among moral theologians came to a head in the late 1800s with the submission of a series of formal questions, or dubia, to the highest doctrinal authority in the Church. The debate concerned pre-viable induction of labor, surgical extraction, and other methods of treating chorioamnionitis, eclampsia, hyperemesis gravidarum, ectopic pregnancies, and other conditions. The Holy Office, later known as the Congregation for the Doctrine of the Faith, issued five replies to the debated issues from 1884 to 1902. These replies presumed the Church's perennial and unchanging prohibition on all direct abortions—even with the noble goal of saving the life mother's life—and clarified that this prohibition included craniotomy (1884) or any other surgical procedure that would directly kill the child (1889), the expulsion of a living child that would result in death from immaturity (1895), and the extraction of an immature ectopic child (1902).[9]

It is important to note that the Holy Office's responses did not rule out the surgical removal of the mother's tissues or organs, such as salpingectomy or hysterectomy, even if the child's death would be a foreseen side effect.

Various faithful moral theologians in recent decades—likely because of certain questions about the exact language used in the Holy Office responses, the lack of a detailed explanation of the distinction between direct abortion and legitimate medical interventions in the replies, and recent advances in obstetrical knowledge and techniques—have argued that certain instances of intact pre-viable induction of labor may actually fall under the principle of double effect and so are not ruled out by the response of the Holy Office in 1895. Stated differently, there have been compelling arguments by Catholic intellectuals and physicians of good will that a pre-viable induction of labor may not be a directly intended killing of the child when the mother's life is in grave and imminent danger.

As noted above, the ERDs do not clearly address whether pre-viable induction of labor can be morally legitimate. The application of Directives 45 and 47 to pre-viability induction has varied in accordance with the interpretation of the language. While ERD 47 acknowledges situations in which the child's life may be lost as a result of maternal treatments prior to viability, such as the hysterectomy for treating cancer, it is not clear whether it also applies to pre-viability induction of labor. Some interpret the description of termination of pregnancy as a "sole immediate effect" and "directly intended" (ERD 45), together with maternal treatments that "cannot be safety postponed until the child is viable" (ERD 47), as allowing the possibility of pre-viability induction to treat conditions like chorioamnionitis, HELLP syndrome, or preeclampsia. Others interpret the phrase "directly intended termination of pregnancy before viability" (ERD 45) to mean that pre-viability delivery is always a direct abortion and therefore morally impermissible, even when the baby is delivered intact and alive though sure to die.

At this time, especially in light of the need for more nuanced guidance following the *Dobbs* decision, the NCBC is reexamining the moral tradition and the more recent debates among moral theologians on the topic of pre-viability induction of labor with the goal of bringing greater clarity to this issue in the near future. What follows is a summary of NCBC guidance in recent decades, which may be updated in light of new findings or additional guidance from the teaching authority of the Church.

When there is no moral certitude that the child has died, the NCBC maintains: (1) surgical abortion procedures of any type, such as dilation and curettage (D&C) or dilation and extraction (D&E), are never permitted; (2) previable induction of labor is not legitimate for underlying conditions of the mother—such as pulmonary hypertension or cardiomyopathy—that are complicated by the normal strains associated with pregnancy;[10] but (3) previable induction of labor can be permissible to expel pathological tissue from the uterus, as in the case of chorioamnionitis or preeclampsia, as this would be a directly intended removal of pathological tissues threatening the mother's life and not a direct abortion.[11]

With respect to this third point, the NCBC has advised very high thresholds of proportionality and moral certitude since it is sure that the pre-viable child will not survive following induction. Accordingly, the NCBC has maintained that previable delivery can only be legitimate when, in the clinician's medical judgment, (1) the pathological condition of the mother resulting from the pregnancy-related condition has progressed to a point where further delay would surely result in the mother's death, and (2) no alternative medical interventions that can save the life of both mother and child are available.[12] The following example can help to explain this point.

When a woman's water breaks prior to viability, an uncontrollable and life-threatening infection may arise in the ruptured membranes and spread to the uterus, making long-term expectant management of the pregnancy impossible. Assuming no alternative intervention to save mother and baby is available, induction of labor may be medically indicated in order to expel the infected tissues and prevent the infection from causing maternal death. In accord with the principle of double effect, early induction may be permissible in this case because it is carried out for the purpose of the saving the mother's life even though the foreseen yet unintended consequence is that the child will die following delivery due to his or her prematurity. The NCBC's guidance would apply the principle of double effect in this way:[13]

1. The act itself, that is the action of inducing labor, is morally good as it expels the infected membranes. It is the appropriate medical intervention to treat the mother's pathological condition.
2. Induction is directed toward the mother's healing and not toward the death of the child.
3. The mother is directly healed of her pathological condition (the infection) by the removal of the infected membranes, not by the death of her unborn child. In other words, the death of her unborn child is not the means by which the mother is healed.
4. Preserving the mother's life in this urgent situation with a lack of better alternatives is a proportionate reason to tolerate the unintended but foreseen loss of her unborn child's life.

Ectopic Pregnancy

An ectopic pregnancy occurs when an embryo implants somewhere other than the uterus. Most often it occurs in the fallopian tube, but it can occur in other places as well. The NCBC's guidance on ethically appropriate treatment options for ectopic pregnancy is based in Directives 45 and 48 of the ERDs and aligns with the traditional application of the principle of totality, which allows for removal of a person's own tissues or organs.

Directive 45 is clear that direct abortion is never permissible, and Directive 48 states that "in the case of extrauterine [ectopic] pregnancy, no intervention is morally licit which constitutes a direct abortion."

If the child has already died, any medically appropriate intervention could be legitimate as it does not constitute a direct abortion. However, any such intervention should aim to (1) preserve the mother's health and life as the priority, (2) respect the remains of the child to the extent feasible without adding undue risk to the mother's life and health, and (3) preserve any identifiable remains of the child for burial or interment in a sacred space.

When the child has not yet died, the meaning and application of the term "direct abortion" is not as clear. While the responses of the Holy Office from 1898 and 1902 prohibited the extraction prior to viability of children implanted ectopically, the teaching authority of the Catholic Church has not offered specific pronouncements on the morality of today's intervention options for ectopic pregnancy. As with pre-viability induction of labor, faithful moral theologians disagree about whether and how the Holy Office replies and the principle of double effect might apply to certain situations involving extrauterine pregnancy.

Based on medical evidence and a rigorous application of Catholic moral principles, NCBC ethicists have generally advised the following on interventions for ectopic pregnancy:[14]

1. Expectant waiting—allowing the ectopic pregnancy to resolve itself naturally—can be permissible and is generally preferable, although it may not be advisable depending on the mother's medical condition;
2. Salpingectomy—the removal of the damaged fallopian tube (either partial or full)—can be permissible as it directly targets the mother's tissues and does not directly target the living implanted embryo;
3. Salpingostomy—the directly intended removal of the living implanted embryo through a typically destructive surgical procedure—is not permissible as it constitutes a direct abortion; and
4. Use of methotrexate (MXT)—a cancer drug intended to dislodge the embryo from the site of implantation—can be permissible if there is moral certitude of embryonic demise (death). If such certitude is lacking, the use of MXT is not permissible because it directly kills the child by attacking the embryonic child's cells (the trophoblast).

Life-Limiting Fetal Diagnosis

In accord with ERD Directives 45 and 50, a life-limiting fetal diagnosis such as trisomy 13, trisomy 18, or anencephaly does not justify direct abortion or referral for direct abortion. Such a diagnosis should result in referral to appropriate maternal-fetal care

THE NATIONAL CATHOLIC BIOETHICS CENTER
600 Reed Road Suite 120 Broomall, PA 19008 www.ncbcenter.org

ETHICS & MEDICS
AUGUST 2022 VOLUME 47, NUMBER 8

specialists so that parents can be informed of medically indicated and morally permissible intervention options.

For children diagnosed with a life-limiting medical condition, prenatal medical interventions should be offered as appropriate. Options for resuscitative and curative measures following birth should be presented to parents, and parental requests for treatment should be honored to the extent they are medically feasible. Perinatal hospice, including pastoral care and counseling for the parents, should be offered as appropriate.

Miscarriage

If an unborn child dies in utero, it is permissible to remove the remains through a surgical procedure if this is indicated for the health of the mother. The procedure used, typically a dilation and curettage, is the same one used on living children in the case of elective abortions—but it is not a direct abortion when the child has already died. Parents should be offered information and options for burial of the child's remains, which may be private burial or a shared burial. Policies and procedures should be in place in the health care facility for the respectable disposition of the baby's remains if the parents do not choose a specific burial option.

John A. Di Camillo, PhD, BeL is the personal consultations director at the National Catholic Bioethics Center. Jozef D. Zalot, PhD is a staff ethicist at the NCBC.

Endnotes

1. Health and Human Services Press Office, "Following President Biden's Executive Order to Protect Access to Reproductive Health Care, HHS Announces Guidance to Clarify that Emergency Medical Care Includes Abortion Services," *HHS*, July 11, 2022, https://www.hhs.gov/about/news/2022/07/11/following-president-bidens-executive-order-protect-access-reproductive-health-care-hhs-announces-guidance-clarify-that-emergency-medical-care-includes-abortion-services.html?utm_source=substack&utm_medium=email.
2. The present article is a discussion and explanation of the existing guidance of The National Catholic Bioethics Center (NCBC) and may not fully reflect the individual opinions of the authors or of the other NCBC ethicists. For the official statements of the NCBC, see Ethicists of the NCBC, "Early Induction of Labor," NCBC, February 2013, rev. 2015, https://www.ncbcenter.org/resources-and-statements-cms/summary-early-induction-of-labor; Ethicists of the NCBC, "The Management of Ectopic Pregnancy," NCBC, February 2013, https://www.ncbcenter.org/resources-and-statements-cms/summary-ectopic-pregnancy; Ethicists of the NCBC, "Maternal-Fetal Vital Conflicts," NCBC, February 2015, https://www.ncbcenter.org/resources-and-statements-cms/summary-maternal-fetal-conflicts; and NCBC, "Statement on Early Induction of Labor," March 11, 2004, http://morninglightministry.org/mlmhopeinturmoil/index.html.
3. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed., available at https://www.usccb.org/resources/ethical-and-religious-directives-catholic-healthcare-services.
4. Pius XI, *Casti connubii* (December 31, 1930), n. 64. See also Peter J. Cataldo, T. Murphy Goodwin, and Robin Pierucci, "Early Induction of Labor," in *Catholic Health Care Ethics: A Manual for Practitioner*s, 3rd ed., ed. Edward Furton (Philadelphia: NCBC, 2020), 14.6.
5. USCCB Committee on Doctrine, "Direct Abortion vs. Legitimate Medical Interventions," USCCB, June 23, 2010, https://www.usccb.org/resources/direct-abortion-statement2010-06-23_0.pdf.
6. The following explanation and application of the principle of double effect follows NCBC, "Early Induction of Labor."
7. Holy Office, Response of the Holy Office to the Bishop of Sinaloa (Mexico), May 4, 1898, DH nn. 3336–3338, q. 1.
8. NCBC, "Early Induction of Labor;" See also Cataldo et al., "Early Induction of Labor," 14.8–14.11.
9. See Responses of the Holy Office, DH, nn. 3258, 3298, 3336–3338, 3358.
10. In the past decade, Catholic authors have proposed that induction of labor may also be legitimate in these situations. The NCBC has not taken this position. See Ethicists of the NCBC, "Maternal-Fetal Vital Conflicts."
11. See NCBC, "Early Induction of Labor;" NCBC, "Maternal-Fetal Vital Conflicts;" and NCBC, "Statement on Early Induction of Labor."
12. See NCBC, "Early Induction of Labor." This summary reads, in part, "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."
13. See NCBC, "Early Induction of Labor."
14. The NCBC has not formally committed to a position on salpingostomy or methotrexate. See NCBC, "The Management of Ectopic Pregnancy."

Ethics & Medics is a publication of The National Catholic Bioethics Center. Regular annual subscription rates for twelve issues include both the print version by mail and online access at www.ncbcenter.org/em: United States, $28; foreign $38; institutional $55. Individual copies are available for $3 each. To subscribe, please write to The National Catholic Bioethics Center, PO Box 596, Wynnewood, PA 19096, e-mail orders@ncbcenter.org, or phone (215) 877–2660. Publisher: Joseph Meaney, PhD. Editor: Edward J. Furton, MA, PhD. ISSN 1071–3778 (print), ISSN 1938–1638 (online). To submit an essay or request submission guidelines, please e-mail submissions@ncbcenter.org. For permission to reuse material from Ethics & Medics, contact the Copyright Clearance Center, Inc. (CCC), 222 Rosewood Drive, Danvers, MA 01923, phone (978) 750–8400, website www.copyright.com. CCC is a not-for-profit organization that provides licenses and registration for a variety of uses.