



## Understanding and Applying the *Ethical and Religious Directives for Catholic Health Care Services:*

AN EDUCATIONAL RESOURCE FOR THE CATHOLIC HEALTH MINISTRY



*Part Four - Issues in Care for the Beginning of Life*

# *Part Four - Issues in Care for the Beginning of Life*

## **CASE STUDY**

### **CASE #1: PRE-TERM PREMATURE RUPTURE OF MEMBRANES**

Linda, a 28-year-old pregnant woman with three children, presents to the emergency department of St. Anthony Regional Medical Center with clinical signs of PPROM. Various tests, clinical assessment, and personal history by the maternal-fetal physician (MFP) on-call indicates that Linda is 18 3/7 weeks pregnant and that, at present, there is no evidence of infection, labor, or fetal compromise. Given this and the gestational age of the fetus, the MFP suggests conservative management consisting of ongoing observation for signs and symptoms of infection, active labor, and/or fetal compromise. While this care plan provides little benefit to Linda, the MFP notes that the potential benefit for her baby can be significant if they can forestall delivery until the baby reaches viability. However, the MFP notes that Linda will have to be on bed rest in the hospital for the duration of the pregnancy because she does not meet one of the criteria for home management, namely living within close proximity to the hospital since her home is in a rural area more than 60 miles away. Though Linda is concerned about the effect this will have on her husband and three children, she nonetheless consents.

After nine days of in-hospital management, Linda becomes increasingly agitated and stressed about her situation and the future outcome of her baby. She complains to nurses of a persistent headache, leg pain, constipation, and hip/back soreness, and has mentioned several times how much a toll this is taking on her husband who must tend to the farm as well as take care of the children. During her visit with the MFP, Linda mentions all this to her and vehemently demands to know what the outcome will be for her baby. The MFP points out that it is hard to know for sure but that if infection and/or preterm labor does not set in there is a good chance that they will get the baby to at least 23 weeks. However, she mentions that the risk of these things occurring is relatively high and that the outcome for her baby even if they get to 23 weeks is still up in the air given the complications that the baby is sure to experience as a result of being born so prematurely. The MFP suggests that if conservative management is too much of a burden on Linda, they could induce delivery now but that her baby would die as a result. Is induction at this time justified under ERD 47? Why or why not?

Linda decides to continue with conservative management despite the burdens she is experiencing. Now at 20 4/7 weeks pregnant, though, Linda spikes a fever, has uterine tenderness, vaginal discharge, and fetal monitoring shows an increased fetal heart rate, all signs of chorioamnionitis. The MFP informs Linda of the change in her condition and suggests that they could initiate antibiotic therapy as well as administer tocolytic drugs but that the likely outcome for her baby is not good given the gestational age and the risks to Linda are significant. After discussing the options available to her with the MFP, Linda decides to induce delivery now even though her baby will die as a result. Is induction at this time justified under ERD 47? Why or why not? (Courtesy of Dr. Michael Panicola, SSM Health Care, St. Louis, Mo.).

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## **CASE RESPONSE**

### **CASE #1: PRE-TERM PREMATURE RUPTURE OF MEMBRANES**

#### **1. What ethical issues do you see here?**

- ◆ Early induction at 18 3/7 weeks.
- ◆ Early induction at 20 4/7 weeks with the development of chorioamnionitis.
- ◆ Direct/indirect abortion.

#### **2. Which Directives apply to the case?**

- ◆ 45, 47

#### **3. How might the Directive(s) help address the case?**

- ◆ Directive 45 makes the distinction between direct and indirect abortion; direct abortion is never permissible, while an indirect abortion might be.
- ◆ Directive 47 describes an indirect abortion. The issue in the case is whether either or both situations meet the conditions of an indirect abortion. It might be helpful to review the definition of “double effect” in the Glossary.

- ◆ In light of Directive 47, the suggestion of the MFP to induce delivery at 18 3/7 weeks is inappropriate and unwarranted as there is no immediate risk to the mother and no serious pathology to be treated that could allow for a double effect. This would constitute a direct abortion.
- ◆ As the case progresses and evidence of chorioamnionitis is clear, the risk to the mother has now changed and a pathology that requires immediate treatment has been documented. The presence of an intrauterine infection poses a grave threat, a life-threatening situation, for both mother and fetus. Induced labor could be justified (Directive 47) under the principle of double effect if other treatments are not possible or the risk to the mother and fetus cannot be mitigated. Removal of the infected placenta and the membranes of the gestational sac are the standard treatment for chorioamnionitis. The fetus is unlikely to survive in either case. It will die from the infection if not delivered or almost certainly die because of its gestational age if delivered. Given the weightiness of this decision, the assistance of pastoral care or social work might be prudent.



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## **CASE STUDY**

### **CASE #2: GENETIC COUNSELING AND PRENATAL DIAGNOSIS**

Nancy and Bill are recently married and want to begin their family. There is an extensive history of cystic fibrosis (CF) in both families, however. In fact, both have siblings with CF. In a conversation with one of her friends, Nancy expresses anxiety about having a child with CF. She is very intent about having a “normal” child. If Nancy and Bill both carry the gene for CF, every one of the children they conceive has a one-in-four chance of inheriting both aberrant genes and getting cystic fibrosis. There is also a 50 percent chance that any child will be a carrier of the aberrant gene. As a carrier, that individual could pass the gene on to his or her offspring.

Nancy’s friend encourages Nancy and Bill to go for genetic counseling and testing. Nancy seeks the advice of her OB-GYN at St. Raphael’s Medical Center, who encourages Nancy and Bill to proceed. He refers them to the genetics program at the medical center. They learn that they each carry the gene for cystic fibrosis. They are devastated.

They are also very confused. Given what they were told by the geneticist, they wonder whether they should even conceive, given the risk to a future child. Or should they take the chance (and possibly burden a child with this disease)? Or should they conceive and then undergo prenatal diagnosis to determine whether or not the fetus has the mutation for cystic fibrosis. Nancy, even though Catholic, believes that if the fetus does have CF, there is the option of abortion. Bill is adamantly opposed to abortion, but Nancy thinks it is sometimes justified. Nancy again seeks the advice of her OB-GYN.

Nancy and Bill decide to take the chance. They do conceive. Nancy goes for prenatal diagnosis (amniocentesis in this case). Her fetus has inherited the CF gene from both parents and, hence, will get the disease. Nancy and Bill are now faced with a decision about what to do regarding the pregnancy. They also wonder about their options with regard to future pregnancies — sterilization, artificial insemination by donor, and in vitro fertilization using donor sperm or egg.

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## **CASE RESPONSE**

### **CASE #2: GENETIC COUNSELING AND PRENATAL DIAGNOSIS**

#### **1. What ethical issues do you see here?**

- ◆ Responsible parenthood.
- ◆ Discrimination against someone with disabilities — what is a “normal” child?
- ◆ Prenatal diagnosis.
- ◆ Abortion.
- ◆ Sterilization.
- ◆ Artificial insemination by donor.
- ◆ In vitro fertilization using donor egg and sperm.

#### **2. Which Directives apply to the case?**

- ◆ 38, 39, 40, 41, 45, 50, 52, 53, 54

#### **3. How might the Directive(s) help address the case?**

- ◆ Directive 54 supports genetic counseling, while Directive 50 supports prenatal diagnosis but not for the purpose of terminating a pregnancy. Directive 45 prohibits direct abortions. An important consideration is whether amniocentesis should even be offered in this case given The mother’s inclination to terminate the

pregnancy, potential risks to the fetus and the fact that there exists no treatment for cystic fibrosis in utero.

- ◆ Pastoral care and counseling should be recommended both prior to the diagnosis and immediately following. The differences of opinion between the spouses on a matter as serious as abortion not only contributes to a misunderstanding of Church teaching and individual spiritual issues, but could also contribute to a serious divide in the marriage
- ◆ In light of the Church’s teaching on the dignity of the human person regardless of condition or stage of life, misunderstandings of “quality of life” and “burdensomeness” should be addressed and the dignity of all persons affirmed.
- ◆ Updated and accurate information should be given regarding the latest treatment options for cystic fibrosis, and the available resources for parents/patients with this condition.
- ◆ Directives 38, 39, 40, 41, 43, 52 and 53 state the Church’s position on various reproductive technologies and contraceptive procedures. The Church considers these to be morally wrong. Information about Natural Family Planning and adoption resources should also be provided.

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## **CASE STUDY**

### **CASE # 3: TUBAL LIGATION FOR MEDICAL REASONS**

Maria is a 28-year-old woman in the 26th week of her third pregnancy. She is obese, a heavy smoker, has used weight loss pills on several occasions, and suffers from type 2 diabetes mellitus. Her previous two pregnancies were complicated.

Maria presents with complaints of progressive exertional dyspnea and fatigue of several weeks duration. She also reported several recent syncopal episodes. After a variety of tests, she was admitted to labor and delivery at St. Michael's Medical Center and was prescribed bed rest, oxygen, diuretics, and heparin. Despite this therapy, Maria continued to report progressive dyspnea. At 32-weeks' gestation, the placement of a pulmonary artery catheter demonstrated moderate primary pulmonary hypertension presenting a significant risk to the mother. Maria was treated accordingly. At 36-weeks' gestation, the patient suffered premature rupture of membranes followed by active labor. The progression of labor was insufficient and a cesarean section was performed resulting in the delivery of a healthy male infant. At the recommendation of her OB-GYN, in order to avoid a future life-threatening pregnancy, a bilateral tubal ligation was performed with the patient's consent. Post-delivery, the patient was treated in the intensive care unit for five days for her primary pulmonary hypertension. She was discharged 20 days later.

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## **CASE RESPONSE**

### **CASE # 3: TUBAL LIGATION FOR MEDICAL REASONS**

#### **1. What ethical issues do you see here?**

- ◆ Responsible parenthood
- ◆ Sterilization

#### **2. Which Directives apply to the case?**

- ◆ 52, 53

#### **3. How might the Directive(s) help address the case?**

- ◆ Directive 53 prohibits direct sterilizations even for medical reasons. A procedure that seeks to treat a present and serious pathology but also causes sterility is permitted if there are no better options. This would constitute an “indirect sterilization.” A tubal ligation performed in order to prevent a future threat to the mother’s health or life would not be permitted. Here the tubal would be viewed as a means to an end and so would not meet the third condition of the principle of double effect.

- ◆ Directive 52 speaks to the importance of conveying to married couples the Church’s teaching on responsible parenthood and methods of natural family planning.



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### **DISCUSSION/REFLECTION QUESTIONS**

- ◆ Upon what does the Church ground its teaching about reproductive technologies and the beginning of life?
- ◆ What is your personal response to this teaching? What difference does this make to your work? To your life?
- ◆ What do you mean when you use the term “sanctity of life?”
- ◆ What do you understand by the covenant of marriage?
- ◆ Why is the Church opposed to heterologous reproduction? In-vitro fertilization?
- ◆ What kinds of prenatal diagnoses are acceptable? Under what conditions?
- ◆ What does Church teaching permit when it comes to problematic pregnancies?

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### PRAYER RESOURCE

#### OPENING PRAYER

O God, author of life, you are the creator of every human person. You give the precious gift of life, sustaining each family, reflecting the love of your Holy Spirit. Fill each family with gratitude for the gift of life. Be with them when they are sorrowful. Be with them when they are joyful. Guide us, support us and give us your grace for this sacred calling. Amen.

#### READING

So God created humankind in God's image, in the image of God he created them; male and female God created them. God blessed them, and God said to them, "Be fruitful and multiply." (Genesis 1:27-28)



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## **ADDITIONAL RESOURCES**

Congregation for the Doctrine of the Faith, “Instruction *Dignitas Personae* on Certain Bioethical Questions,” (September 8, 2008).

Congregation for the Doctrine of the Faith, “Responses to Questions Proposed Concerning ‘Uterine Isolation’ and Related Matters,” (1993).

Congregation for the Doctrine of the Faith, “Instruction on the Respect for Human Life in Its Origin and on the Dignity of Procreation,” (1987).

Congregation for the Doctrine of the Faith, “*Quaecumque Sterilizatio*: Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals (1975),” *Origins* 10 (1976): 33-35.

Congregation for the Doctrine of the Faith, “Declaration on Procured Abortion,” (1974).

deBlois, Sr. Jean and Rev. Kevin O’Rourke, “Care for the Beginning of Life,” *Health Progress* 76, no. 6 (September-October 1995): 36-40.

John Paul II, “The Gospel of Life,” *Origins* 24, no. 42 (1995).

United States Conference of Catholic Bishops, “Moral Principles Concerning Infants with Anencephaly,” *Origins* 21, no. 44 (1992).