Direct Abortion or Legitimate Medical Procedure

Double Effect?

John W. Seeds, M.D.

Dr. Seeds is a professor at Virginia Commonwealth University in Richmond, Virginia. He may be contacted at jseeds@vcu.edu.

Abstract

The distinction between direct abortion and legitimate medical procedures deemed necessary to save the life of the mother but resulting in the death of the unborn child challenge all clinicians and persons of faith. A careful analysis of the principle of double effect and a recent statement by the Committee on Doctrine of the United States Conference of Catholic Bishops offer some clarity to this difficult conflict. Two case examples offer illustration for the analysis.

Introduction

Direct abortion is never morally permissible. One may never directly kill an innocent human being, no matter what the reason.¹

Catholic physicians, and more specifically Catholic obstetricians, can face, on an almost daily basis, clinical challenges to their faith. A myriad of maternal and/or fetal medical conditions that impose an increased risk of maternal and/or fetal death can require the physician to make choices between the apparent welfare of the mother and the life of the unborn child. If clinical circumstances are believed to require an intervention that results in the ending of a pregnancy before a gestational age at which neonatal survival is possible (twenty-three to twenty-

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four weeks post-menstrual), then the death of the infant will result. Are such interventions, however necessary to save the life of the mother, always considered abortions that are forbidden by the Catholic Church? Is a Catholic physician required by his faith to stand by and watch his or her patient deteriorate and die?

The United States Conference of Catholic Bishops (USCCB) has provided guidance for Catholic health-care institutions and health-care workers in its *Ethical and Religious Directives for Catholic Health Care Services*, most recently revised in 2009. Two of these directives are relevant:

Directive 45: Abortion (that is, the *directly intended termination* of a 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.²

and

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.³

These directives may appear to be in conflict. At the bedside and in the context of emergent clinical circumstances, how should the Catholic physician resolve this conflict? Do these two directives constitute a form of double speak, or might the “double effect” principle (doctrine) guide the moral analysis and help resolve what could be misconstrued as a contradiction?

Case Examples

While there are many possible examples of clinical situations to illustrate such dilemmas, two may be useful:

Case 1: The first patient is a twenty-five-year-old mother at twelve weeks gestation in her second pregnancy. Her first pregnancy ended with a term birth complicated by severe pre-eclampsia. Approximately two weeks post-partum she developed shortness of breath, exercise intolerance, and dependent edema; and she was found to have cardiomegaly on chest x-ray. Echocardiography showed biventricular dilatation and a left ventricular ejection fraction of 25 percent (normal >55 percent) with no structural cardiac abnormalities. A diagnosis of idiopathic post-partum cardiomyopathy was made. She was treated with angiotensin converting enzyme (ACE) inhibitor, furosemide, and digoxin, and she improved significantly; but one year later, she remained symptomatic upon mild exertion, and an echocardiogram showed that her heart function remained compromised at 25 percent. She was short of breath with minimal exer-

tion. Pregnancy was strongly discouraged. Her current pregnancy was unplanned but desired. Treatment with lisinopril was discontinued and beta blocker therapy begun. Diuretic treatment and digoxin were continued. At eight weeks of gestation her physicians counseled her that carrying her current pregnancy to term was dangerous and that her risk of peri-natal death could be as high as 30 to 50 percent. They recommended abortion. She declined. Treatment with diuretics, digoxin, and beta blockers was continued, but at twelve weeks her condition deteriorated and she was admitted to the hospital. She was symptomatic at rest with shortness of breath and her oxygen saturation was 90 percent on two liters of oxygen by nasal cannula. Chest x-ray was consistent with moderate pulmonary edema. Echocardiography again showed biventricular dilatation and a left ventricular ejection fraction of 20 percent. She was counseled that the pregnancy had imposed a burden on her heart that it was unable to tolerate and that abortion was necessary to save her life. She agreed and a dilatation and evacuation (D&E) was performed.

Case 2: The second patient is a twenty-seven-year-old mother at seventeen weeks in her third pregnancy with di-amniotic, di-chorionic twins. She had two small children at home. She had an uncomplicated obstetrical history. She experienced a spontaneous rupture of membranes at home that was confirmed by sterile speculum examination on admission to the hospital. She was accompanied by her husband. Ultrasound confirmed that both twins were consistent with seventeen weeks of development, alive, and one had virtually no amniotic fluid while the other had a normal amount. On admission the mother was afebrile, asymptomatic, with no uterine tenderness or contractions. Expectant management was initiated and prophylactic antibiotics were begun. Within twelve hours of admission, however, she developed a fever of 102 °F, and shortly after that she developed abdominal (uterine) tenderness, tachycardia, and chills. Her white blood cell count rose to twenty-two thousand. Broad spectrum therapeutic antibiotics were begun, and she was counseled that the only medically acceptable treatment was to begin oxytocin to stimulate labor and empty the uterus of the infected contents. She was told that antibiotics without the removal of the infected tissue would not be adequate and that life threatening sepsis would be the likely outcome. She and her husband agreed. Oxytocin was begun, and delivery was accomplished. The infants were pre-viable and died.

Discussion

Are these two cases morally different? Was either intervention acceptable in the context of Catholic moral teaching? Is the ethical principle of “double effect” helpful in the examination of these cases? Does Church teaching recognize the principle of double effect?

The principle of double effect in the analysis of moral or ethical conflicts is said to have originated in the thirteenth century with St. Thomas

Aquinas's justification of self-defense.⁴ The doctrine recognizes that there are circumstances in which a justifiable action may have both a good and an evil result. In simple terms, if you kill an attacker (some would say the killing is an evil result) to save yourself (a good result), your action may be justified. Learned scholars have examined this doctrine for hundreds of years, and a full discussion would be expansive; but its fundamental elements may be concisely contained in four conditions that must be met for double effect to suggest that an action with both good and evil results may be justified:

- 1) The action must be itself morally good or at least neutral: the action cannot be intrinsically evil.
- 2) The good result must flow from the action, not from the evil result; the evil result cannot directly produce the good result.
- 3) The evil outcome cannot be intended, although it is an anticipated outcome.
- 4) There must be a proportionate good result to permit the evil result.

So how do these principles apply to killing in self-defense? The very act of killing someone to defend yourself from being killed begs the analyst for a careful nuance of meaning. Is not killing someone intrinsically evil? Perhaps it is, but in killing someone who is, in your view, trying to kill you, you are not killing an innocent person. Further, you could argue that you only intended to stop the attacker from killing you, not necessarily to kill him. The death of the attacker was, in that sense, an indirect and unintended outcome. Furthermore, the attacker's death was not necessary to preserve your life; it was necessary only to intercept the attacker and disable his ability to kill you. If you intended the death of the attacker, the balance of this analysis would change. So, criteria 1, 2, and 3 of double effect may be met by careful construction of the facts. Finally, you would easily argue that criterion 4 is met since most of us would assert that the death of the attacker, though unintended and regrettable, would be tolerable because of the proportionate preservation of our own life.

What about the two clinical obstetrical cases described above?

In the first clinical case, the mother's underlying cardiac condition was not caused directly by the current pregnancy. Her deterioration may or may not have been the indirect result of the current pregnancy. While many reports document the high maternal mortality associated with pregnancies in women with persistent, significant left ventricular dysfunction, the outcome is not perfectly predictable.⁵ By twelve weeks' gestation, the added physiologic burden on the maternal cardiovascular system associated with pregnancy is significant, but it is not certain that ending the pregnancy would result in any immediate benefit to her. Maternal blood volume expansion and increased cardiac output normally begin as early as six weeks' gestation and peak at thirty-two to thirty-four weeks, but may increase by as much as 30 percent as early as twelve

weeks.⁶ The expected benefit of abortion (recovery of cardiac function) may not necessarily result from the action (the D&E). Also, while the D&E procedure, that is, the dilatation and evacuation of the uterus, is not, in and of itself, intrinsically evil, in this case where the direct and intended result is the destruction of the living fetus, it takes on an evil identity. The death of the fetus was the direct result of the action, and the expected benefit was predicated on the death of the fetus.

Importantly, the patient typically does not have the education or background to dispute the medical analysis or recommendations being provided and must rely on the information given by her physicians. In this case, she was told the pregnancy was directly causing her deterioration and that abortion was required to save her life. Published experience supports this pessimistic view. In one series of patients with peripartum cardiomyopathy, 54 percent of patients ultimately recovered normal cardiac function, but 41 percent demonstrated persistent left ventricular dysfunction, 4 percent of these required transplantation, and 9 percent of those with persistent dysfunction died.⁷ The reported maternal mortality rate associated with pregnancy in those patients with persistent left ventricular dysfunction was 17 percent. However, the response, in these circumstances, to the termination of pregnancy is uncertain and largely speculative. In any health-care environment where termination decisions are reviewed by an ethics review committee, the committee is itself often reliant on the information provided by the clinical attending physician. The burden of accuracy is on the physician, and while that physician may well sincerely believe in the advice he or she is providing, a second opinion from experts not directly involved in the case can serve a critical role to be sure that the advice is medically appropriate in any particular case and that there are no medically reasonable alternatives.

In the second case, the mother's life-threatening condition of chorio-amnionitis and developing sepsis was the result of infected tissue within her uterus that included living pre-viable twins. While antibiotics were promptly begun, antibiotics by themselves were not considered adequate; and the medically accepted definitive treatment was the removal of the infected tissue including the membranes, placenta or placentae, and fetuses.⁸ Again, the administration of a drug to stimulate uterine contractions is not in itself an intrinsic evil, although clearly this action, intended to cause the expulsion of the source of the infection, the infected tissue, also caused the expulsion of both fetuses with their placentae. The secondary and anticipated but unintended effect was the delivery of pre-viable fetuses resulting in their deaths. While the deaths of the twins were not the desired or the intended result of the action, it was foreseeable and unavoidable. Furthermore, the death itself of the twins was not required to treat the mother's infection, it was an unavoidable secondary result of the induced delivery.

Had the rupture of membranes occurred just seven to eight weeks later in this pregnancy and resulted in a similar infection, the survival of

the twins might have been possible with the same therapeutic intervention. So the death of the twins was not the therapeutic necessity, and the good result for the mother did not flow directly from their deaths. An analysis of the proportionality of the survival of the mother of two small, living children compared to the unavoidable deaths of the twins may be influenced by consideration of the certain death of the twins if the mother died with or without the action to remove the infected tissues. The evolution of sepsis and likely death of the mother would also have resulted in the deaths of the twins.

Conclusion

The statement by the Committee on Doctrine of the USCCB is intended to bring clarity to the distinction between direct abortion and legitimate medical procedures. The first case involved a D&E that directly targeted the life of the unborn child and caused the child's death. The action did not directly benefit the mother's condition. Any possible benefit to the mother was indirect. The death of the unborn child was the direct result of the action. The USCCB statement says that "direct abortion is never permissible because a good end cannot justify an evil means."⁹ The statement by the USCCB does not specifically reference, but does rely upon, the principle of double effect. Furthermore, it presents a clear distinction between medical procedures that directly destroy a living human embryo or fetus and those necessary treatments that may indirectly result in the death of an unborn child.¹⁰

In the second case, the death of the twins was the indirect result of a medically necessary action that directly treated the patient's life-threatening infection. The death of the twins, while regrettable, was not directly intended, nor did their death directly cause the good effect of the mother's recovery from the infection. The mother did directly benefit from the action to remove the infected tissues.

Sincere individuals may disagree with these conclusions. All moral analysis requires definitions and perspectives that can vary and complicate the ability to achieve agreement. Assume that the surgeon in the first case did not desire the death of the unborn, and assume that he or she sincerely believed that the pregnancy was directly responsible for the deterioration of the mother's cardiac function. The action itself, nevertheless, according to the statement by the Committee on Doctrine, must be considered to be a direct abortion because the death of the child was the direct purpose and result.

In the second case, the death of the unborn twins was the unintended result of the action in question. Furthermore, the death of the twins was secondary, not the intended or necessary result, and the action was the necessary direct treatment of the mother's and fetus' life-threatening conditions.

At the bedside, in the midst of emergent circumstances, the thoughtful analysis of conflicting benefits can be difficult. Sincere and well-meaning people can reach conclusions they later regret. It is important to review these issues prior to emergent events. The principle of double effect can provide a framework for useful discussion, but care must be taken in the construction of the analysis to avoid the influence of bias. A careful reading of the statement of the USCCB Committee on Doctrine and of directives 45 and 47 of the *Ethical and Religious Directives for Catholic Health Care Services* does provide clarity on the distinction between direct abortion and medical procedures that may be considered morally licit, and does so in a manner consistent with the principle of double effect. Primary-care physicians, priests, and hospital chaplains, all of whom may be called upon to provide counsel or advocacy for patients facing such difficult decisions should examine these documents before the emergent moment arises.

Notes

¹ United States Conference of Catholic Bishops, Committee on Doctrine, "The Distinction Between Direct Abortion and Legitimate Medical Procedures" (2010), <http://www.priestsforlife.org/magisterium/bishops/10-06-23-direct-abortion.pdf>.

² United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, D.C.: USCCB: 2009), dir. 45, <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

³ Ibid., dir. 47.

⁴ Thomas Aquinas, *Summa theologiae* II-II, q. 64, a. 7.

⁵ J.F. Pyatt and G. Dubey, "Peripartum Cardiomyopathy: Current Understanding, Comprehensive Management Review and New Developments," *Postgraduate Medical Journal* 87 (2011): 34–39.

⁶ C.S. Brown and B.D. Bertolet, "Peripartum Cardiomyopathy: A Comprehensive Review," *American Journal of Obstetrics and Gynecology* 178 (1998): 409–414.

⁷ U. Elkayam et al., "Pregnancy Associated Cardiomyopathy: Clinical Characteristics and a Comparison between Early and Late Presentation," *Circulation* 111 (2005): 2050–2055.

⁸ R.S. Gibbs, "Premature Rupture of the Membranes," in *Danforth's Obstetrics and Gynecology*, eds. R.S. Gibbs et al. (Philadelphia: Lippincott Williams & Wilkins, 2008), ch. 12, 194–195.

⁹ USCCB, "The Distinction Between Direct Abortion and Legitimate Medical Procedures."

¹⁰ Ibid.