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PROBLEM:

The issue to be examined in this consultation is whether or not it is ethically permissible to induce labor for a woman with a viable anencephalic fetus, who is experiencing severe abdominal pressure, discomfort and shortness of breath due to polyhydramnios, and severe emotional trauma caused by the diagnosis. Since the physical problems are apparently not life threatening, it is difficult to answer in the affirmative based solely on the physical symptoms. The heart of the issue, then, is the psychological state of the woman. Are severe psychological trauma and resulting deep depresson "proportionate reasons" for ethically justifying the induction?

MEDICAL (PERINATAL) CONSIDERATIONS:

As stated in WILLIAMS OBSTETRICS, pp. 1069-70,

> Anencephalus is a malformation characterized by complete or partial absence of the brain and the overlying skull. In most cases, there is no brain tissue except a small mass composed of a few glial cells distributed between the larger vessels.

With regard to the clinical aspects of this condition, diagnosis is usually made by the inability to palpate a fetal head abdominally, the presence of increased amniotic fluid (hydramnios) and is confirmed by ultrasound and/or radiologic examination.

The main consideration with regard to care of a woman who has an anencephalic fetus is whether to initiate labor as soon as the diagnosis is confirmed. Waiting for spontaneous labor is, of course, the most judicious plan, since it provides a greater degree of safety to the mother. Induction of labor through the use of I.V. Oxytocin will sometimes initiate labor, but

the uterus containing an anencephalic fetus is not as conducive to stimulation as another one would be. Most often slow removal of amniotic fluid, coupled by the I.V. medication, will effect delivery.

Due to the fact that hydramnios occurs in about 90% of anencephalic pregnancies, relief of the symptoms and alleviation of the fluid load almost always initiates labor. In cases of "moderate" hydramnios, even those with accompanying discomfort and shortness of breth, the patient can be treated non-aggressively until labor begins or the membranes rupture spontaneously. When treatment consists of periodic amniocentesis, with removal of a certain amount of fluid, the possibility of premature labor must be considered (since the removal of even a small amount of fluid can initiate labor).

Therefore the question comes up: When is this treatment to be instituted and what are the risks/benefits to mother and fetus involved?

ETHICAL ISSUES AND THE CHURCH'S TEACHING:

"Personhood" of the fetus:

As has been stated earlier, anencephalus is a condition involving absence of brain tissue. There are varying degrees of severity in cases of anencephaly. As one of the staff members of the Pope John Center stated in a Memorandum with regard to fetuses with "almost the entire brain being absent":

> In this latter extreme, it is likely that this is not a human being since an essential component for the functioning of a unified human being and the root of all potentiality for rationality would be absent. However, in most cases it is difficult to ascertain if this extreme of anencephaly actually exists; more often, in most cases, not all, there is some brain tissue left including especially the brain stem which is necessary for the basic vital functions such as respiration and proper cardiac activity.

The question remains about determining the certainty of this absent part of the brain and its relation to personhood. In an article written by the Pope John XXIII Center staff in *Hospital Progress,* Nov. 1983, it is stated:

> The problem remains that science cannot at present give any reasonable certainty that brain structure, including the brain stem, is totally absent. Therefore, ethically, physicians MUST assume that an anencephalic fetus IS a human person and must respect that such a fetus has a right to the womb as its primary life-support system. This right precludes expelling the fetus from the womb before viability.

Otherwise this would be abortion. As Directive #12 of the ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH FACILITIES states:

> Abortion, that is, the directly intended termination of pregnancy before viability, is never permitted, nor is the directly intended destruction of a viable fetus . . . .

INDUCTION OF LABOR:

Over the last 28 years, for induction to be justifiable there had to be certain medical indications. As Fr. Gerald Kelly, S. J. states, (MEDICO-MORAL PROBLEMS, 1958, p. 147):

> To be justifiable, the elective induction of labor supposes the existence of certain indications that the mother is physiologically ready and that the baby is sufficiently mature.
>
> Induction before the proper signs are present can be justified only for definite medical reasons which would warrant the running of one risk in order to avoid a greater risk for baby and/or for mother.

In other words, the risk to the mother and/or fetus would be outweighed by the benefits of the delivery, after viability.

The question of the mother's condition in this particular case, and in similar ones, is what needs to be further explored. As Directive #23 states in the ETHICAL AND RELIGIOUS DIRECTIVES:

> For a proportionate reason, labor may be induced after the fetus is viable.

Can the psychological trauma or emotional turmoil brought about by the diagnosis of anencephaly be a sufficient or proportionate reason to induce labor before term? The "medical reasons" alluded to above may very well include psychological or psychiatric considerations.

As Msgr. Orville Griese, Director of Research at the Pope John XXIII Medical-Moral Research and Education Center in Massachusetts states:

> If the mother is subject to such psychiatric repercussions over the anguish of carrying such a seriouisly handicapped infant and there is no other alternative to sedating her fears and anxieties, a case could be made for inducing labor soon after viability has been definitely diagnosed.

Naturally, the earlier a fetus is removed from the uterus, the more risk there is to that fetus. Therefore only the most serious physical or mental distress on the mother's part would justify a pre-term delivery, and then only after viability. This serious condition of the mother would then outweigh in a proportionate manner the risks to the fetus and herself and would ethically justify an early delivery.

PSYCHIATRIC CONSIDERATIONS:

The decision to have an induction should not be made in haste. To do so would only reinforce and increase the woman's depression and guilt. As the DIRECTIVES insist, the total good of the patient is paramount in treatment: "The total good of the patient, which includes his higher spiritual as well as bodily welfare, is the primary concern of those entrusted with the management of a Catholic health facility" (p. 1). The emotional and psychological state of the patient is certainly one aspect of the total person and an aspect that must be addressed if wholistic health care is not to become a mere platitude.

This means, among other things, that a psychiatric evaluation is a necessity in cases of this sort. As Directive #7 puts it:

> Adequate consultation is recommended, not only when there is doubt concerning the morality of some procedure, but also with regard to all procedures involving serious consequences . . . .

Once the diagnosis of an anencephalic fetus is made, the husband and wife need time to decide their course of action. It is certainly a violation of Christian justice to inform the woman of the diagnosis and to initiate the procedure the same day. The family simply has not had enough time to evaluate the situation, as the mother and father are usually in emotional shock. We note, then, the need for a psychiatric interview and subsequent sessions so as to prepare the family for the reality of the situation and to aid them in the process of clarifying their emotions and desires.

If, in the psychiatric evaluation, it is determined that the situation has or is leading to prolonged mental anguish or to a psychotic condition on the woman's part, there is ethical justification for induction. Or, if it is determined that the woman's psychiatric condition is (or may be) leading to prolonged periods of disability (psychosis, depression, etc.), and that such a situation is negatively affecting the family (the love relation is in danger of being ruptured, say), there is "proportionate reason" to initiate the induction. Put differently, the quality of the woman's life and the quality of family life are two essential concerns in making this decision.

CARE OF THE DELIVERED ANENCEPHALIC INFANT:

An anencephalic infant, once delivered, is usually not capable of living beyond a few hours or days, since s/he is in effect born "dying". Treatment of this infant demands the assurance of ordinary measures of care, such as warmth, air, comfort, affection, sanitary conditions (so as to prevent infection), fluids to prevent dehydration, analgesics when necessary to alleviate pain and bonding measures which the infant can sense. In other words, care of this infant, whose life span is very short, should be as humane as possible. There would be NO moral requirement to use aggressive or extraordinary means to maintain the infant's life, since that kind of treatment would only prolong the dying process. As stated in the DECLARATION OF THE SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH ON EUTHANASIA (May 5, 1980), contained in THE POPE SPEAKS (p. 295):

> When death is imminent and cannot be prevented by the remedies used, it is licit in conscience to decide to renounce treatments that can only yield a precarious and painful prolongation of life. At the same time, however, ordinary treatment that is due the sick in such cases may not be interrupted.

ETHICAL CONCLUSIONS:

1. The physician has the moral responsibility for determining accurately the diagnosis of anencephaly and the length of gestation, and providing

the woman and her family alternatives of treatment.

2. If the fetus is viable, and there is a proportionate reason to induce labor before term gestation is reached (as explained in the above guidelines), then the physician may proceed with induction of labor which will promote a higher benefit to risk ratio and effect a safe delivery for the mother.
3. The method of induction should promote/assure a higher degree of benefit than risk.
4. It is unethical and not acceptable in a Catholic health facility to directly intend the termination of a pregnancy before viability, since this would be abortion.
5. Two human individuals with equal rights to life are involved in this type of case (the mother and the handicapped fetus). Thus, procedures have to be evaluated in relation to protecting the rights of both.
6. Since an anencephalic infant is born dying, humane treatment by ordinary measures MUST be given to this infant and aggressive or extraordinary means of sustaining life would be left to the reasonable desires of the parents.
7. It would be ethically permissible for a Catholic health facility to allow induction of labor, after the stage of viability has been reached for a "proportionate reason." One such "proportionate reason" is psychiatric turmoil — prolonged mental anguish and psychotic episodes being two cases in point. Another "proportionate reason" is a medical condition which is life threatening.
8. All women whose fetus has been diagnosed as anencephalic should receive a psychiatric evaluation, with on-going therapy just after the diagnosis has been made — and with therapy after the decision if necessary.
9. These guidelines need to be reviewed and adapted by the facility's ethics committee. Also, an education program needs to be developed for both patients and the medical staff regarding the issue of an anencephalic fetus — the ethical and medical aspects to be highlighted.

SELECTED READINGS:

1. Staff of the Pope John XXIII Medical-Moral Research and Education Center, "How Should Catholic Hospitals Treat An Anencephalic Fetus?" *Hospital Progress,* November, 1983. St. Louis, MO., pp. 50-51.
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3. Kelly, Gerald S. J., *Medico-Moral Problems,* Catholic Health Association: St. Louis, MO. 1958, Chapter 18.

4. O'Donnell, Thomas J. S.J., *Medicine and Christian Morality.* Alba House/Society of St. Paul: New York. 1976, pp. 203-206.

5. Hellman, Louis M. and Pritchard, Jack A., *Williams Obstetrics.* 14th Edition. Appleton-Century-Crofts: New York, 1971, pp. 1069-1072.

6. "Declaration of the Sacred Congregation for the Doctrine of the Faith on Euthanasia", May 5, 1980, *The Pope Speaks.*