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THE MORAL ASPECTS OF THE Rh FACTOR

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THE essentially civilizing and culturing influences of moral theology and Christian ethics arise from the fact that they emphasize so incessantly and so insistently in our lives the human and the divine values of our actions, that a person who lives under the bright and challenging light of moral ideals and ethical realities can never be oblivious of their omnipresent and their omnipotent dynamism. A person who is aware of the importance of the dictates of morality and of moral theology can never successfully ignore them; can never successfully escape the power of their influence; can never expect to escape beyond the reach of the warning finger of conscience or the threatening finger of God's long suffering, or beyond the glowing warmth of the God-man's love.

There are actions which in themselves are pronounced to be unworthy of a man by the dictates of one's own conscience. There are other actions which of themselves merit the full approval of one's own conscience. There is a third class of actions which derive their moral value not so much from their own selves but from the circumstances surrounding them, circumstances which are in many instances entirely within the limits of control by the individual and which, therefore, achieve a moral significance by reason of the individual's attitude towards them.

In one sense of the word, the Rh factor has no moral value. As far as research has revealed its nature, it is a biological reality, comparable in practically all respects, as far as morality goes, to any one of literally thousands of substances occurring in the human body, each effecting a biological result in the biological economy of the organism, each conditioning the general well being of the organism and each either essential or necessary or desirable in the organism. Whether we are Rh positive or Rh negative is not a matter of morality any more than whether we belong to any one of the four recognized blood groups.

In what sense, therefore, do we speak of the moral aspects of the Rh factor? In this very obvious sense, that the possession of the Rh factor or its absence in either the mother or the father has been made the occasion or excuse (a) for contraception, (b) for abortion, (c) for radical obstetrics, and (d) for preferential mating involving the conduct of

engaged couples or of those who might plan to be engaged. The morality associated with the Rh factor arises from the use which a physician might make of his scientific knowledge in guiding individuals either in married life or outside of it; or it arises from the use which a man or woman might himself or herself make of the knowledge concerning the Rh factor in his or her conduct.

I.

Can the Rh factor justifiably be made an occasion for contraceptive practices? Before we answer this very important question, let us recall that in accordance with the teachings of the Church and the findings of sound ethics, the practices of contraception are contrary not only to divine but also to natural law. Onanistic practices are admittedly forbidden in the Jewish as well as the Christian revelation but they are equally forbidden by reason of the conclusions of the reasonable dictates of the human mind as it supplies materials for the judgment of conscience which direct the individual human being in his daily conduct. This is not the place nor the occasion for arguing this point. It is, however, the place and the occasion for guarding ourselves against fallacious conclusions even though these might be sincerely dictated in any given set of circumstances by seeming sympathy for a young married couple who, so it is alleged, are kept apart by reason of the fear of the possible consequences of the enjoyment of those experiences to which the sacrament of Matrimony has given them the full right of enjoyment. A young married couple has an uneventful but intensely happy experience in the birth of their first child. The second child is born sickly with symptoms that are today but too easily recognized. The health of the child wanes and the child dies. The third child might be stillborn and premature; the fourth might survive the threats of delivery but may present a pitiable appearance with its characteristic facial habitus or, which God may forbid, its continuous convulsive state, and its accompanying mental retardation.

We may paint the picture as black as we will. A physician is seen in each of these deliveries. If he is not aware or chooses not to be aware of the moral obligation of such a couple, whether they be Catholics or non-Catholics makes no difference, since we are dealing with a precept of the natural law, except that only Catholic couples will worry and be anxious about their obligations, he will counsel the application of one of his favorite contraceptive devices. It is here that the moral aspects of the Rh factor come into play. The physician insists that there may be no more children but since it is beyond all human expectation that the married couple will practice that self-restraint through which alone the physician's injunction can be made a reality, the physician simply dismisses his patients with the advice that they themselves are the only ones who can prevent the occurrence of another pathological child.

There can be no doubt about the reality which I am here trying to picture nor can there be doubt about the essential seriousness of the situation and of the almost super-human demand which ethical living makes upon some married couples. But after all, what essential factors are there in this situation that are not present in countless others in which continence is demanded by the moral law if other consequences, fateful though they be, are to be avoided?

The physician puts this married couple, through his advice, into the dilemma either of enjoying their rights or of accepting the consequences of another stillborn or pathological child. Be it noted that if the married couple accepts the alternative of continuing to enjoy their rights, there is no certainty that a pathological offspring or a stillborn fetus will eventuate. Rather, if we can accept statistics, diseased and healthy children may follow each other in a variable and hitherto undetermined sequence. Many a healthy child of a multipara has been born after a pathological or stillborn child and as far as the Rh factor is concerned, both biological considerations as well as statistical experience bear out the correctness of the contention that statistically, the birth of a healthy child might well be expected after the occurrence of the diseased or pathological member of the family. Neither the occurrence of a positive or negative father with a negative or positive mother nor the incidence of two parents who are both Rh negatives can give any certainty as to the expectations of either a pathological or normal offspring. Furthermore, the early post partum recognition and competent intensive treatment if the disease is resulting in a reputed reduction in mortality and an increase in clinical cures. If, therefore contraceptive advice is given prior to conception of the offspring and merely on the occurrence of a negative Rh test in the mother, the advice would seem to be unjustifiable; if it is given after the birth of a pathological child, it is given on a false presumption that the next child must certainly or probably be pathological.

I know that this logic, no matter how strict it may be, and inconvertible by reason of its cogency, does not solve some deeply human problems in which the threat to the continued integrity of the marriage bond of two well-intentioned and ardent Catholic young people might be endangered by a series of catastrophic events, each more poignant in its grief for father and mother than its predecessor. But again, let me point out, that contraception is no answer to the reality of the sufferings endured by a young married couple under those conditions; rather must the couple be safeguarded and strengthened and protected against the inroads of a false philosophy of life which would see in physical suffering the deepest and greatest of all human misfortunes and which would neglect for such a misfortune the sublime teachings of Christ Who by word and example taught the inexhaustible sublimity of human suffering, the ennobling character of agony endured for His sake and Who upon the Cross gave us the significant example of His three hours of loneliness in the

midst of the hootings and cries of the assembled multitude. It seems cruel, but a couple having had such experiences cannot be encouraged to abuse their marital rights but must be taught how wisely, prudently and circumspectly they may enjoy those rights, but always within the law established by God.

II.

Can knowledge concerning the Rh factor be used to encourage interruption of pregnancy by abortion in order to prevent the live birth of an erythroblastic child? Concerning actual practice with reference to this question, there is little if any positive and accurate information. Surmises, however, are uncomfortably frequent. Suggestions have been made by some physicians, though scarcely in published papers, that this matter be approached in the same way as one would approach therapeutic abortion, namely, that adequate consultation be called and that only upon the agreement of the required number of consultants should the attending physician proceed. The thinking leads to a concept akin to the thought which might be expressed by such a phrase as "therapeutic euthanasia," that is, the prevention of continuous life of a fetus which would or might or could result in a pathological child.

Such thinking is, of course, entirely unethical and must be judged ethically and morally by all the criteria and standards by reason of which we flatly condemn any other voluntary abortion, even therapeutic abortion, as generally understood. But in this case, there is even less biological or medical justification for the abortion than there is in other alleged necessary abortions since we do not possess the knowledge that would justify such a procedure even if it were ethically and medically allowable. It is well known that we do not have any way of judging prior to birth just what the hematological conditions of the fetus is. Even the most careful study of the mother's blood during the entire period of pregnancy cannot yield a conclusion concerning the probable or possible occurrence of an erythroblastic child. A demonstration of sensitization of the Rh-negative mother during pregnancy may mean and probably does mean the development of an erythroblastic infant but the degree, extent or precise nature of the pathology cannot be judged directly from the findings concerning the sensitization of the mother's blood. Besides, even when increases in the mother's sensitization are demonstrated, healthy Rh-positive births may result.

If this is correct, there can be no medical reason which I can see for counselling abortion in the case of the pregnancy of a sensitized Rh mother. There is, therefore, no medical reason for applying to the problem of the moral liceity of abortion any other considerations than those which apply to abortions in general. The principle which the Catholic physician follows in judging of such liceity are well known, are recognized by Catholics and non-Catholics alike. Abortions are finding less and less medical justification as medical research progresses and we

are approaching in this question, the statement which marks the remarkable culmination of so many other questions in medicine in which conflicts were thought to exist between the medical and the moral viewpoints. I refer to the dictum which to my mind needs continuous re-emphasis, namely, that good moral practice is good medical practice and good medical practice is good moral practice, and that if there is an alleged or apparent conflict between morality and medicine, it is because the physician does not know his medicine or the moralist does not know his moral theology or his ethics. It seems unnecessary to labor this point because the ethical and moral arguments against abortion are well understood and are easily applied to our present problems.

III.

Can knowledge concerning the Rh factor justify radical obstetrics? The answer to this question must be approached quite differently from the answer to the previous one for the simple reason that Cesarian section is often the approach of choice for the physician who is confronted with a difficult moral problem in medical practice and who desires to solve that problem in accordance with the dictates of natural or revealed morality. Nevertheless, even though Cesarian section under certain conditions is ethically and morally permissible, it must still be regarded as an unusual obstetrical procedure which requires medical justification as the basis for its moral justification. It is unnecessary here to amplify this statement but the statement itself does recall ever so many of the physician's obligations with reference to the practice of surgery, gynecology, obstetrics and of all the other related surgical procedures. A Catholic physician will be mindful of all these considerations. An unnecessary operation is morally unjustifiable. Moreover, often must an elective operation be submitted to the most careful scrutiny and the most careful application of moral and medical criteria before it may be ethically performed. Endangering the life of a patient unnecessarily, mutilating the patient, causing the patient unnecessary expense and delay in a hospital with the attending anxieties and worries for herself and her family, all these and literally hundreds of other considerations enter into the problem of justifying an operation. For this reason, the many safeguards which we employ to ensure good surgical practice, such as, the recording of a pre-operative diagnosis, the submission of all biopsied tissues to the pathological laboratory, the pathologist's corroboration or non-corroboration of the pre-operative diagnosis, the review of the operative procedure in history meetings and in the clinical pathological conferences, all these and related procedures are at the same time safeguards of good surgical practice and of good moral practice and constitute the serious concern of any physician who takes seriously the sublime vocation of medicine and its supreme demands upon the moral integrity of the medical practitioner.

Applying this thinking to the problem in hand, there have been medical advisors and consultants who have counselled the interruption of pregnancy by Caesarian section in the last few weeks of pregnancy, such judgment being based upon the serological detection of increased sensitization of the mother as pregnancy progressed.

We may revert here to our comments made in the previous section of this paper. If the theories upon which our present thinking is based are correct and if there is a relationship between the acuity and intensity of the disease in the fetus and the relative amount of the antibodies detectable in the mother's blood which in some way find their way through the placental wall, it would seem that Caesarian section and the consequent liberation of the premature fetus from the threat of the massing of antibodies in the fetal circulation would seem to be the approach of choice for the prevention of progressive erythroblastosis. Following this line of reasoning, the suggestion has been made that as soon as the developing fetus is viable, it should be delivered by radical obstetrics to prevent the progressive accumulation of antibodies derived from the mother's circulation.

But warnings have been issued against this over-simplification. The literature is becoming more and more complex as the result of an increasing amount of research and our failure to comprehend how the results of such research will be integrated in the final synthesis of our knowledge. A recent editorial in the *Journal of the American Medical Association* warns us that: "There is little to recommend Caesarian section as a means of saving babies with erythroblastosis. Too many disappointments have been experienced. The handicap of prematurity is rarely outweighed by the alleged shortening of exposure to the damaging action of maternal Rh antibodies." (*J.A.M.A.*, November 9, 1946, page 581). The editorial goes on to express the same thought which I have attempted to express in the previous section: "The crux seems to be our inability thus far to recognize with certainty the severity of the disease in the baby by the examination of the mother's blood." (*Ibid.*).

IV.

The approach to the last question which I have raised, namely, what bearing our knowledge of the Rh factor has upon pre-marital advice concerning courtship and the possible moral problems involved in the choice of a partner, reaches out even beyond the immediate interests of medical practice into the recondite areas of human heredity. It would seem almost foolhardy to enter upon a discussion of the moral problems associated with all of this at a moment like the present when certainly the required time for discussing these matters is surely not at our disposal. And yet perhaps, a few generalizations may be considered tentative and entirely anticipatory of the confirmation of present day findings by future research.

Some conclusions bearing upon the matter in hand are even today not only probable but almost approach scientific certainty. There can be no reasonable question any longer in anyone's mind concerning the occurrence in the blood cells of certain individuals of a factor in the nature of an agglutinin which has been named the Rh factor and which is not related to any one of the known and recognized blood types. Evidence is also accumulating to an extent that is most impressive that while Rh-negative individuals mating together and Rh-positive individuals mating together need not anticipate, except under conditions recognized by the human geneticist and in this case, by the human immunologist, the birth of an erythroblastic child, the mating of a Rh-negative female with a Rh-positive male may result in a small but still important percentage of instances in an erythroblastic child. When a Rh-negative female mating with a Rh-positive male, no untoward results in the way of an erythroblastic first child need be anticipated unless the mother has been sensitized at almost any time in her pre-pregnancy life by the transfusion of Rh-positive blood through which transfusion she has produced antibodies to Rh-positive blood. The anticipation with regard to subsequent children is, of course, entirely different.

All of these statements would have to be modified to make them rigorously correct, for the complexity of the genotype of the Rh-positive factor has been a matter of intense research not only by the original group of investigators, namely, Landsteiner and Wiener, but also by the British investigators working in Race's laboratory. Race has recognized the occurrence of a complicated allelomorph series of seven mutations in the Rh gene. We know that the gene occurs in some other than the sex chromosome and, therefore, the occurrence of the factor in the red cells is not sex linked which fact introduces additional complications into the study of the heredity of the Rh factor. It is true that evidence is accumulating to show that erythroblastosis occurs in the male in about three times the frequency in which it occurs in the female and that it is fatal in about five times as many male infants as in female infants but these facts may be secondary even though the possibility cannot be disregarded that we are dealing with some kind of modification of a sex linked characteristic, or possibly with some kind of secondary consequence of the male constitution.

If one now bears in mind that we are in all likelihood dealing with seven allelomorphs which we refer to as Rh₁, Rh₂, Rh₀, Rh¹, Rh¹¹, rh and Rhy and that any one of these may occur in each of the pair of allelomorphous chromosome, it is not surprising that the complexity here runs well into the hundreds of possible combinations on this score alone. If we add to this the occurrence of the Hr factor and its possible series of allelomorphs, we have an extremely complicated picture before us.

I am entering into these details merely to show how futile it would be to use any of this information at the present time as a basis of pre-

marital advising regarding human mating. I wish to emphasize the thought too, that anticipatory fears regarding matings based upon the possible occurrence of erythroblastic infants, certainly outrun the present day findings of scientific research. They should not, therefore, and must not be made the basis of moral judgments. Advice cannot be justified that a Rh-negative girl should not marry a Rh-positive man even if it were known that the girl has previously received transfusions. Least of all would it be justified to forbid such a marriage on moral grounds for fear that the result of a pregnancy might be an erythroblastic infant. Of course, I cannot sanction the advice which has allegedly been given by some birth control clinics that such matings as the one I am here discussing should be allowed because if an erythroblastic child should occur, there are ways of dealing with the situation as I have tried to indicate above.

Clearly, it is not my place here to enter into a discussion of the therapeutics of the erythroblastic infant. There is, however, one phase of the question which demands a sufficiently thorough understanding on the part of the physician if he is to give the advice required by the gravity of the Problem. Blood transfusions to the erythroblastic infant are usually given from Rh negative donors. Evidence is accumulating and opinion is consolidating that in many instances transfusion of Rh-positive blood should be the procedure of preference. In this connection, I would point out that advice given by the physician implies the moral obligation of maintaining competence in those fields in which the physician has cast his medical practice. There enter here those extremely exacting instances in which a physician must balance scientific likelihood against certain moral obligation, when we say, for example, "Let your conscience be your guide," but the important thing to note is that before we apply conscience to some of these vexed problems, we must be able to apply a well informed mind to the problems, so that conscience might be ready to pass its moral judgment. I am tempted to leave this phase of the question at this point but it would be unfair to do so both to my own thinking and perhaps to this audience.

We must remember, first of all, that not every marriage of a Rh-negative woman with a Rh-positive man results in erythroblastic infants. In the words of the Journal of the American Medical Association: "Only one in from twenty-five to fifty Rh-negative wives of Rh-positive husbands become sensitized to the Rh factor and give birth to babies with erythroblastosis." In the light of this fact, the promotion of sensational group fears is certainly far from justified. Even if erythroblastic children occurred, there is every hope that through accumulating knowledge and research, problems related to the moral aspects of suspected Rh matings will yield to scientific research. It is heartening that large scale studies, such as those undertaken by the Baltimore Rh Typing Laboratory, are in progress. The service of this laboratory for a relatively small fee is

accessible to the patients of any of the hospitals of Baltimore and to any applicant. Blood groupings are determined and Rh typing is attempted. Samples of blood giving positive reactions are screened. Those giving negative or doubtful reactions are further tested. The serum of all patients showing Rh-negative blood are tested for antibody content. The husbands of women having Rh negative blood are requested to come to the laboratory for typing. If they are found to be Rh-positive, further studies are made to determine the geno-type of their Rh-positive character. Families thus selected are followed during the entire period of pregnancy without additional cost. During the first six months, the tests are repeated monthly and more frequently during the last three months. The reports are sent to the physician of the couple and when necessary, the officials of the laboratory advise with the physician concerning the further conduct of the pregnancy. Assuming, as we do in this case, competence, sincerity, a truly social purpose elevated by a moral purpose, the approach is surely correct. From such studies we may expect conservatism and security of outlook, the avoidance of sensationalism, the maintenance of proper secrecy in diffusing privileged information and, most of all, the furtherance of the therapeutic problems in dealing with the erythroblastic infant.

V.

This paper must be regarded as a premature but sincere approach to the definition of the moral problems connected with the Rh factor. I have tried to show that our present knowledge concerning the Rh factor cannot be taken as an excuse for propagandizing for contraception, neither can it be taken as an occasion for reducing our moral abhorrence for abortion. It would seem, moreover, that any knowledge which we now have of the Rh factor cannot justify a diminution of our attitudes of scientific and moral caution towards radical obstetrics.

Finally, I see no justification for pre-marital advice which would prevent the marriage of even those men and women in whom we recognize the occurrence of those Rh types from which admittedly the larger percentage of erythroblastic children have been derived. This latter judgment is based upon the presumed occurrence of erythroblastic children even from other than the more commonly recognized mating and upon the fact that an impressive percentage of allegedly erythroblastic infants, upon autopsy, are found to have died from other causes than Rh factor crossings.

And yet, when all is said and done, erythroblastic infants have occurred and families have been destined to carry the overwhelming cross of pathological infants and the brothers and sisters of such infants have been confronted even in their tender childhood with the sorrows of a relative whose condition is a challenge to human endurance, patience and kindness. All this is true and yet, it cannot be made the basis for any

of those immoral and unethical practices to which we have referred, it cannot be made the excuse for infant euthanasia. If we permitted such immoral or unethical practices in the case of erythroblastic infants, there would soon be pleadings concerning mothers who have contracted pelves who have endured abruptio placentae and before long, there would be given to us by medical authority perhaps or by administrative authority, a long list of conditions which would be deemed "intolerable" in civilized society.

For us who have faith, there is another solution. Suffering is not an unmixed evil. An erythroblastic infant is destined for the eternal bliss of heaven as much as any other infant; the parents and brothers and sisters of such a child may be blessed because that child may be for each of them the occasion of graces and blessings untold for God's glorification and their own eternal salvation. The erythroblastic infant was included in Christ's invitation and perhaps it might have been chiefly included: "Suffer the little children to come unto Me and forbid them not for of such is the kingdom of God."

