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by

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Directive 45 of the *Ethical and Religious Directives for Catholic Health Services* states: "Abortion, that is, the directly intended termination of pregnancy before viability is never permitted." Directive 49 states: "For a proportionate reason, labor may be induced after the fetus is viable." A question has arisen as to whether these two directives are consistent with the deliberate induction of labor, *after viability*, in the instance where a mother is carrying a baby with a prognosis for only a short term survival (such as anencephaly, renal agenesis) or multiple congenital anomalies with a prognosis for survival of approximately one year (e.g. trisomy 13, trisomy 18). Some institutions have inappropriately included congenital anomalies with a prognosis for long term survival such as Down Syndrome and Meningomelocele in this type of management.

The paradigmatic case involves the question of early delivery of an infant with anencephaly.[1] Since the anencephalic infant has such a uniformly brief prognosis and should receive only comfort care after birth, it lends itself more readily to an illustration of the moral principles involved.

The ultimate intention of those recommending early delivery would be the morally good intention of eliminating anxiety on the part of the parents of the deformed and/or handicapped child.[1] The justification proposed for this type of management is that early delivery constitutes an indirect rather than a direct abortion. An indirect abortion occurs when the goal of the act is to produce a therapeutic benefit to the pregnant woman and the death of the fetus is a necessary but unintended effect of the therapeutic procedure. The distinction between a direct and an indirect abortion is an application of the principle of double effect.

The intention inherent in the early delivery is that the infant with handicaps will not survive. The goal of the action is thus the direct killing of an innocent human being. The legitimate application of the principle of double effect would require that the death of the infant should be an indirect effect of the morally licit intention of reducing or eliminating parental anxiety.[2] Since the goal of the action of early delivery is the direct killing of an innocent human being, the principle of double effect would not be tenable.

The early delivery of a viable infant can only be justified if the infant can no longer live safely in the womb. For example, in the case of amnionitis resulting from premature rupture of the membranes after viability, the prognosis for survival of the infant may actually be enhanced by premature delivery providing that the infant is immediately introduced into the supporting environment of a neonatal intensive care unit.

In the instance where a viable human being with a uniformly fatal prognosis is deliberately delivered early (e.g., anencephaly, renal agenesis) the institution of useless neonatal intensive care support would be contraindicated if not unethical. Thus, the intention of early induction of delivery is not to enhance the possibility of survival but rather to guarantee the death of an innocent human being. The principle of double effect does not apply since the good intention of improving the psychological reaction of the parents is achieved through the immoral action of directly killing the infant.

If early induction of labor cannot be justified in the case of an anencephalic infant who will "die anyway," usually in a week or less, it cannot be accepted where the infant has a longer expectation of survival, such as Trisomy 13 or Trisomy 18. Deliberate induction of prematurity in the case of Down Syndrome or Meningomyelocele is obviously a form of fetal euthanasia and is mentioned only to be condemned. The child with low-meningomyelocele operated on early will have a likely prognosis of normal intelligence and community ambulation with braces. Recent advances in the mainstreaming of children with Down Syndrome is legendary.

Whereas extraordinary surgical and medical procedures such as closure of the defect and shunting would be indicated in most neural tube defects, complicated cardiac surgery and other high-technology management would not be indicated in uniformly fatal syndromes such as Trisomy 13 and Trisomy 18.

Alternative Management

Several recent studies have pointed out the necessity of adequate informed consent before ultrasonic screening is undertaken.[3,4,5] M ny

women are not aware of the scan's potential to detect abnormalities. Many women whose pregnancies would have ended in spontaneous perinatal loss are thus being faced with having to make an active decision about whether to continue their pregnancy. Without full explanation of the technology, patients may be unprepared for bad news or a period of uncertainty. Unlike patients at high risk who have amniocentisis, these women have not had the advantage of contemplating the early induction of labor in a planned and wanted pregnancy. Not all women will want to know their baby is abnormal and not all women will choose to terminate their pregnancy if it is. Psychological support has been defined as an objective of scanning for abnormality[6] and evidence indicates that psychological morbidity after early induction may be as high as that of spontaneous perinatal loss. Acute grief reactions were observed in 78% of women who had termination for fetal malformations.[7] This was equal to that of stillbirth and neonatal death and much higher than that associated with miscarriage(6%).

Health professionals may not associate the classic grief reaction with losses in the perinatal period because the family has not become "attached" to the baby or fetus. There is strong evidence to the contrary. Kennell points out that "Strong affectional bonding appears to begin before *physical contact and caretaking."*[8]

It is important in the management of this grief reaction that the parents be encouraged to mourn actively. Phrases such as "It's for the best" or "You can always have another child" tend to evoke anger because they deny the parents' right to grieve.[9] Gulber[10] reported pathologic mourning in 34% of mothers studied. The facilitation of normal grief reactions may minimize the occurrence of abnormal grief.

Before parents can accept the death of their baby, they must perceive that it actually existed. This requires that the mothers and fathers see and touch and hold their baby in private surroundings.[11] It is probably advisable that the child be given a name and parents who wish to have a funeral should not be discouraged.

Psychological support should continue after the mother is discharged from the hospital and plans future pregnancies.

Although management of the pregnancy of a mother carrying an abnormal baby by early induction of labor is frequently proposed as a way of minimizing suffering of parents and child, it is best evaluated against alternative options. Semantic manipulations notwithstanding, it is most appropriately evaluated as a form of third trimester abortion.[12]

The most common error is to apply the principle of beneficence to the fetus and not to the survivors. There is almost invariably an inadequate appreciation of the importance of prenatal bonding. The mourning reaction after perinatal death occurs in all parents regardless of term of gestation or birth weight. Proper management of perinatal death must facilitate normal

grief. The justification of third trimester abortion by an appeal to the expected opportunity to conceive a subsequent child contradicts proper management of perinatal death and the principle of beneficence. It not only fails to benefit or relieve suffering but it also is a source of suffering because it contributes to the likelihood that mourning will be incomplete.[13]

Summary

1. Early induction of labor in women carrying abnormal children with poor prognosis has been proposed as a treatment for maternal anxiety.

2. Induction of labor in such instances constitutes a direct attack on an innocent human being and cannot be justified under the principle of double effect.

3. There is considerable evidence that allowing the pregnancy to go to term and then to allow parents to mourn actively and appropriately may be the best way to guarantee favorable psychological outcome for patients.

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