Early Induction of Labor Summary

From the *Ethical and Religious Directives for Catholic Health Care*
#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.
#49. For a proportionate reason, labor may be induced after the fetus is viable.

Viability:

In most "first world" countries, the limit for fetal viability is 23 weeks of gestation — survival of children born at 23 weeks is about 10%, and most survivors have major handicaps. In pregnancy, because there are two patients who are interdependent, mother and fetus, their interests often conflict to some degree. After viability has been reached, the burdens associated with continuing the pregnancy compared to the burdens of early induction of labor must be carefully weighed with respect to each patient in an attempt to maximize clinical outcomes for both. Sometimes early induction of labor after viability will be indicated when there is significant risk to fetal health (but mother would be unaffected) if the pregnancy were to continue, e.g. fetal hemolytic disease (where incompatibility between maternal and fetal blood causes destruction of fetal red blood cells). Before viability is reached, the Principle of Double Effect may allow for early induction of labor, with foreseen fetal demise as a consequence, in certain severe cases.

Early Induction of Labor Before Viability is Sometimes Justifiable by the Principle of Double Effect:

A. Morally Acceptable Grounds [Proportionate Reasons] for Early Induction of Labor:

1. The presence of serious infection [chorioamnionitis], e.g., following preterm premature rupture of membranes (PPROM).

2. The presence of serious maternal illness deriving from pregnancy, e.g., preeclampsia, H.E.L.L.P. syndrome.

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3. Controversy exists as to whether a woman with severe heart disease, who may or may not be able to tolerate the added stress of increased blood volume and swelling from the pregnancy, may undergo early induction. Even though the placenta is causing the increased blood volume in the mother, this is a normal part of pregnancy, not a pathological condition *per se*. The pathology of her weakened heart is not directly remediated by early induction, so there is debate about whether the Principle of Double Effect might be validly applied in these circumstances.

B. Morally Unacceptable Grounds [Disproportionate Reasons] for Early Induction of Labor:

1. In order to prevent possible infection after complications, e.g., following PPROM. "Expectant management" [e.g. antibiotics and steroids with close monitoring] can result in fetal survival and acceptable maternal morbidity. If evidence of intrauterine infection develops, however, an urgent life-threatening situation can arise, and early induction based on A(1) above will generally be indicated.

2. Fetal anomalies incompatible with life, e.g., anencephaly, renal agenesis, certain skeletal dysplasias with failure of thoracic development, some cases of trisomy 18 (Edwards' Syndrome) with severe cardiac defects, Trisomy 13 (Patau's Syndrome), other rare trisomies, and triploidy, unless any of these conditions result in a life-threatening situation for the mother.

3. If there is a fetal anomaly incompatible with life, the mere fact that the child has reached viability does not justify early induction.

4. Severe fetal anomalies compatible with life, but resulting in grave disability or very short lifespan, e.g. certain chromosomal defects, massive hydrocephalus, and hydrancephaly.

5. Non-lethal anomalies, resulting in serious disability, but not generally life threatening, e.g. Trisomy 21 (Down Syndrome), omphalocele, and neural tube defects.

6. Emotional distress to the mother.

