Making Sense of Bioethics
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Father Tad Pacholczyk
Director of Education
The National Catholic Bioethics Center

When Pregnancy Goes Awry

"Yet the difference in how the baby dies is, in fact, critical. There is always a difference between killing someone directly and allowing someone to die of indirect causes."

Human pregnancy begins whenever a sperm unites with an egg inside the fallopian tube. The newly-minted embryo must then travel along the fallopian tube during the next few days before finally implanting into the wall of the mother's uterus.

In rare instances, the embryo will fail to reach the uterus, and will instead implant in the fallopian tube along the way, which is a very narrow tube not designed to support a pregnancy. Such "tubal pregnancies" are highly risky, because the wall of the tube can stretch only a limited amount before it will rupture from the increasing pressure of the growing fetus, possibly resulting in the death of both mother and child.

Whenever an embryo implants in the wrong place, whether in the fallopian tube or in another place like the abdomen, such a pregnancy is called "ectopic" (meaning "out of place"). Ninety-seven percent of all ectopic pregnancies occur within the fallopian tube. Ectopic pregnancy is one of the leading causes of maternal sickness and death in the United States, and presents a formidable challenge to the physician who is trying to help both mother and child.

Of the three commonly performed procedures for addressing ectopic pregnancies, two raise significant moral concerns while the third is morally acceptable.

The first procedure involves a drug called methotrexate, which targets the most rapidly growing cells of the embryo, especially the placenta-like cells which attach the early embryo to the wall of the tube. Some have suggested that methotrexate might preferentially target these placenta-like cells, distinct from the rest of the embryo, so that it could be seen as "indirectly" ending the life of the embryo. Others, however, have noted that these placenta-like cells are in fact a part of the embryo itself (being produced by the embryo, not by the mother), so that the use of methotrexate actually targets a vital organ of the embryo, resulting in his or her death. A number of Catholic moralists hold that the use of methotrexate is not morally permissible, because it constitutes a direct attack on the growing child in the tube, and involves a form of direct abortion.

Another morally problematic technique involves cutting along the length of the fallopian tube where the child is embedded and "scooping out" the living body of the child, who dies shortly thereafter. The tube can

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then be sutured back up. This approach, like the use of methotrexate, leaves the fallopian tube largely intact for possible future pregnancies, but also raises obvious moral objections because it directly causes the death of the child.

Interestingly, both procedures are normally presented to patients exclusive of any moral considerations. They are framed strictly as the means to assure the least damage possible to the mother's reproductive system. Many doctors will admit, however, that these techniques usually leave the fallopian tube scarred, increasing the chances for another tubal pregnancy by setting up the conditions for a recurrence.

About half of the cases of tubal pregnancy will resolve on their own, with the embryo being naturally lost without the need for any intervention. When an ectopic pregnancy does not resolve by itself, a morally acceptable approach would involve removal of the whole section of the tube on the side of the woman's body where the unborn child is lodged. Although this results in reduced fertility for the woman, the section of tube around the growing child has clearly become pathological, and constitutes a mounting threat with time. This threat is addressed by removal of the tube, with the secondary, and unintended, effect that the child within will then die.

In this situation, the intention of the surgeon is directed towards the good effect (removing the damaged tissue to save the mother's life) while only tolerating the bad effect (death of the ectopic child). Importantly, the surgeon is choosing to act on the tube (a part of the mother's body) rather than directly on the child. Additionally, the child's death is not the means via which the cure occurs. If a large tumor, instead of a baby, were present in the tube, the same curative procedure would be employed. It is tubal removal, not the subsequent death of the baby, that is curative for the mother's condition.

Some say that cutting out a section of the tube with a baby inside is no different than using methotrexate because, in either case, the baby ends up dying. Yet the difference in how the baby dies is, in fact, critical. There is always a difference between killing someone directly and allowing someone to die of indirect causes. We may never directly take the life of an innocent human being, though we may sometimes tolerate the indirect and unintended loss of life that comes with trying to properly address a life-threatening medical situation.

Rev. Tadeusz Pacholczyk, Ph.D. earned his doctorate in neuroscience from Yale and did post-doctoral work at Harvard. He is a priest of the diocese of Fall River, MA, and serves as the Director of Education at The National Catholic Bioethics Center in Philadelphia. Father Tad writes a monthly column on timely life issues. From stem cell research to organ donation, abortion to euthanasia, he offers a clear and compelling analysis of modern bioethical questions, addressing issues we may confront at one time or another in our daily living. His column, entitled "Making Sense of Bioethics" is nationally syndicated in the U.S. to numerous diocesan newspapers, and has been reprinted by newspapers in England, Canada, Poland and Australia.