

CARDIOLOGY AND HIGH RISK PREGNANCY – A CATHOLIC PERSPECTIVE

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There are a number of areas within Cardiology where ethical concerns arise and where opportunities are presented to put forward the Catholic vision of how medicine and science can be practiced without compromising religious belief and conscience. These areas include high-risk pregnancy and stem cell research; this paper focuses upon these two issues.

HIGH-RISK PREGNANCY.

Most women with cardiovascular pathology have no significant problems associated with pregnancy. There is a favourable outcome for both mother and child in the vast majority of such cases. It must be acknowledged, however, that there are a number of rare but important cardiovascular conditions where the life and health of the mother is placed at increased risk by pregnancy. Among the most important conditions with recognised increased risk are: Eisenmenger's syndrome (the development of pulmonary hypertension secondary to underlying congenital heart disease with initial left to right shunting and eventual reversal of shunt), Marfan's syndrome with significant aortic involvement, pulmonary vascular obstructive disease and cases of previous peripartum cardiomyopathy with persistent significant heart failure.

As a result of the increased maternal risk associated with these conditions most, if not all, current textbooks and guidelines generally state that these patients should be offered "termination" in early pregnancy.

But what is the evidence that abortion should be offered to women with certain cardiovascular diseases during pregnancy? If we believe that all human life, from the moment of conception, is sacred and of equal value the advice that direct abortion should be carried out can not be morally justifiable. But is there an alternative approach to problems of this magnitude that is morally acceptable and realistic?

I grew up in Ireland where there is still a different outlook on the value of unborn life. While Ireland undoubtedly has its problems and attitudes may have changed in recent years, the state gives equal right to life for the unborn child through a constitutional amendment approved by a large majority of the Irish people (67%) in 1983.

"The State Acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and as far as practicable, by its laws to defend and vindicate that right".¹

While the exact wording has been criticised it would be very difficult, if not impossible, to find a better safeguard to protect the unborn child from the evils of abortion while, at the same time, recognising the equal right of the mother to have her life protected. The most vociferous protests against the Amendment wording have come from pro-abortion groups. There is little doubt that this amendment has helped to prevent the practice of abortion in Ireland. At the same time, it would be naïve to believe that Ireland is not affected by abortion as between 4,000 and 5,000 Irish girls and

women travel to the UK each year to have abortions carried out. That figure remains a national disgrace and a tragedy.

As a result of continuing dissatisfaction with the amendment wording and a perplexing interpretation of that wording by members of the Irish judiciary the Irish government established a parliamentary committee to investigate the question of abortion from many different aspects including social, cultural, economic, religious and medical perspectives. Submissions were invited from all interested groups and individuals. The outcome of the investigation, including verbatim reports of discussions between the committee members and invited individuals from all sides of the argument was published in 2000.²

Among the submissions, and consistent with previous statements made at the time of the initial referendum in 1983, the Irish Institute of Obstetricians and Gynaecologists, through Prof. John Bonnar, stated that

“ In current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby, due to extreme immaturity. In these exceptional situations failure to intervene may result in the death of both mother and baby”.²

In this statement he acknowledges that situations very occasionally arise where risk is present to both mother and unborn child and, while every effort should be made to save both, sometimes this may result in the unintentional death of the unborn child. He was specifically referring to cases such as cancer of the cervix or uterus during pregnancy. In these situations, treatment including hysterectomy needs to be considered. If the pregnancy is well advanced, there is a chance that the foetus may still survive despite the necessary intervention and premature delivery. In some situations, however, especially in early pregnancy, it may not be possible to save the life of the child as a result of the essential treatment provided to the mother.

The statement continues “We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother”.²

In all cases of high-risk pregnancy, every effort should be made, and very often is successfully made, to save the life of both mother and child without resort to intentional abortion.

In his submission to the Committee, Prof Eamon O’Dwyer from the University of Galway added “After 40 years as a Consultant Obstetrician Gynaecologist, I can state:

- there is no conflict of interest between the mother and her unborn child;
- there are no medical indications for abortion;
- there is no risk to the mother that can be avoided by abortion;
- prohibition of deliberate intentional abortion will not effect, in any way, the availability of all necessary care for the pregnant woman.

There is therefore a fundamental difference between abortion procured with intent to abort, for social reasons for example, deliberate , intentional destruction of unborn life... and destruction of unborn life incidental to requisite medical treatment which is lawful and ethical, however distressing.”²

This position is entirely in keeping with the teaching of the Catholic Church which, while condemning direct abortion recognises the reality of secondary or unintentional effect of legitimate treatment.

“Abortion, that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable foetus, is never permitted...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.”³

The Medical Council of Ireland, at least until very recently, has also supported this position. In the Council’s Fitness to Practice Guidelines it stated, “the deliberate and intentional destruction of the unborn child is professional misconduct”.⁴ It is interesting to note that the use of the term “abortion” was deliberately avoided as it was considered a lay term and open to a variety of interpretations. The Council statement went further. “Should a child in utero suffer or lose its life as a side-effect of standard medical treatment of the mother, then this is not unethical. Refusal by a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct.”⁴

This direction is consistent with the position adopted by Irish Obstetricians in clinical practice and with the teaching of the Catholic Church. After the amendment to the constitution was successfully passed, the pro-abortion lobby claimed that it would result in the deaths of many Irish women because they would no longer be able to receive standard treatment during pregnancy if complications arose. This scare mongering caused some alarm but, as stated by Prof Bonnar and Prof O’Dwyer, the same standards of treatment continue as before. No mothers have lost their lives as a result of the amendment recognising the right to life of the unborn. Many Irish girls and women continue to travel to the UK for abortion but none do so for life-threatening medical reasons, as confirmed by statistics. In fact, the World Health Organisation (WHO) consistently states that Ireland remains the safest country in the world for pregnant women with the lowest maternal mortality rate of 1 per 100,000 live births reported in 2005.⁵ The UK has a maternal mortality rate of 8 per 100,000 live births. Ireland also has the lowest adult lifetime risk of maternal death at 1 in 47,600. This WHO statistic represents a calculated probability that a 15-year-old girl will eventually die from a maternal cause. Ireland has the lowest such risk in the world.⁵ The risk in the UK stands at 1 in 8,200. The Irish statistics relating to Obstetric practice therefore suggest that the provision of abortion services does not necessarily reduce maternal mortality risk.

WHAT ABOUT HIGH-RISK PREGNANCY AND SPECIFIC CARDIOVASCULAR DISEASES?
WHAT IS THE EVIDENCE IN RELATION TO THE PERCEIVED RISKS?



decades.

Cardiology, more than any other medical discipline, is highly dependent on large-scale clinical trials for developing management strategies. Thus we have multitudes of trials involving thousands and tens of thousands of patients to guide us in the management of heart failure, myocardial infarction, hypertension, hyperlipidaemia and so on. Cardiovascular disease and pregnancy is different. There are no large-scale trials to help us. In fact, there are no trials. There are several small-scale series of case reports, anecdotal cases and “expert opinions”, many of these dating back several

Consider, for example, cases of pulmonary hypertension, including Eisenmenger's syndrome, in pregnancy as these conditions are generally considered to be at the most dangerous end of the spectrum in relation to the risk they present to the pregnant mother. From historical observations, the quoted maternal mortality rates range from 25% to 50%. In the UK, abortion is routinely offered to women with these conditions found to be pregnant. Most women probably accept the advice, without question, to allow their child to be deliberately destroyed. Some decide courageously to continue with the pregnancy to give their child the chance of continuing to live.

A recent study from the Royal Hallamshire Hospital in Sheffield suggests survival rates can be improved in high-risk pregnancy with pulmonary hypertension and is worthy of attention.⁶ The study demonstrates that successful outcomes can be achieved with a carefully-planned, multi-disciplinary approach, making use of available treatments and technologies and that alternatives to abortion are worth serious consideration, even in high risk situations.

As with several earlier reports, it was a retrospective observational study with small numbers. The data was gathered from a specialist quaternary referral pulmonary vascular unit. Nine women with ten pregnancies were included and these represented all of the cases between 2002 and 2009 where the decision was taken by the mother to proceed with pregnancy despite co-existing pulmonary hypertension secondary to a variety of underlying causes, including 3 cases of Eisenmenger's syndrome. Five other pregnancies were also considered for the study but in three cases the mothers later chose to proceed with abortion and in one woman's case she suffered two spontaneous miscarriages.

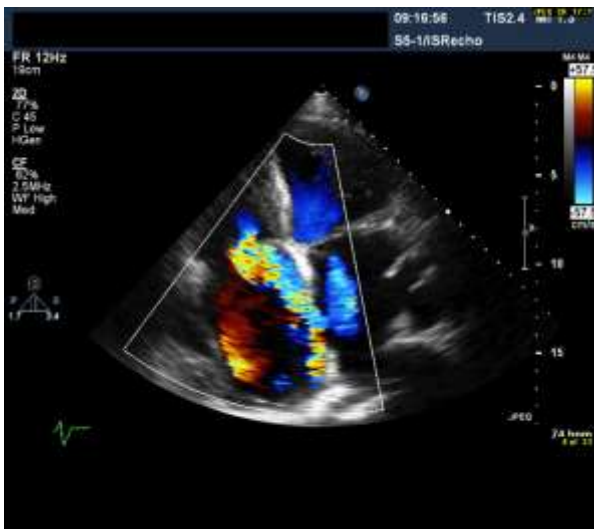
The data referred to cases managed between 2002 and 2009. The reason for choosing 2002 as the starting point is interesting. At that time, specific targeted therapies became available for use in these conditions in pregnancy for the first time. Both maternal and foetal outcomes were measured.

All patients were treated with nebulised iloprost several times per day. If deterioration was noted the treatment was intensified to IV iloprost infusions +/- the addition of oral sildenafil. All babies were delivered between weeks 26 and 37 weeks. All were planned caesarean section deliveries except in one case where spontaneous labour and subsequent normal vaginal delivery occurred. All patients received regional anaesthesia. All were monitored closely in a critical care setting for at least one week after delivery as the risk for the mother continues for at least this period.

There were no maternal mortalities during pregnancy and in the immediate post-partum period. Unfortunately, one mother died at 4 weeks after delivery but she had decided not to continue with her follow-up therapy and declined to attend for continuing care, refusing hospital admission when her condition deteriorated. All of the babies survived with no congenital abnormalities. Follow-up with continued survival persisted for all remaining mothers and all of the infants for a median 3.2 year period.

The authors of this report concluded that:

"The risk of maternal mortality with pulmonary hypertension in pregnancy remains significant. Outcomes can be improved with a tailored multiprofessional approach involving the early introduction of targeted therapy, early planned delivery and regional anaesthetic techniques."⁶



This study offers hope to women with high-risk pregnancies and to their children. It also challenges the medical and nursing professions to consider that there are alternatives to abortion in these rare cases and in other cases where “termination” is currently routinely offered to pregnant women.

It seems reasonable to ask some key questions in relation to situations where abortions have been carried out for perceived medical reasons:

- Could the outcome have been favourable if procured abortion had not been performed and if the pregnancy had been allowed to continue, at least until foetal viability?
- Was abortion really necessary to save the life of the mother?

Looking at the evidence from Obstetric practice in Ireland, supported by WHO statistics in relation to maternal mortality and considering the evidence from the Sheffield study described above the answers to these crucial questions must be that outcomes are favourable in the vast majority of high risk cases without resorting to abortion and that abortion does not need to be considered to save the life of the mother.

ON THE QUESTION OF INTENTIONAL ABORTION, THE CATHOLIC CHURCH HAS NO DOUBT ABOUT WHAT IS RIGHT AND GOOD AND WHAT IS EVIL, AS CLEARLY STATED IN HOLY SCRIPTURE AND IN TRADITIONAL CHURCH TEACHING:

“Thou shalt not kill.”^{7,8}

“Direct abortion is gravely contrary to the moral law” CCC 2271

“Direct abortion, that is to say, abortion willed either as an end or a means, is gravely contrary to the moral law”⁹

“It is true that the decision to have an abortion is often tragic and painful for the mother, insofar as the decision to rid herself of the fruit of conception is not made for purely selfish reasons or out of convenience, but out of a desire to protect certain important values such as her own health...Nevertheless these reasons, and others like them, however serious and tragic, can never justify the deliberate killing of an innocent human being.”¹⁰

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