

2-1-1999

Ectopic Pregnancy: Current Treatment Options, *deja vu Humanae Vitae*

John E. Foran

Follow this and additional works at: <http://epublications.marquette.edu/lnq>



Part of the [Ethics and Political Philosophy Commons](#), and the [Medicine and Health Sciences Commons](#)

Recommended Citation

Foran, John E. (1999) "Ectopic Pregnancy: Current Treatment Options, *deja vu Humanae Vitae*," *The Linacre Quarterly*: Vol. 66: No. 1, Article 3.

Available at: <http://epublications.marquette.edu/lnq/vol66/iss1/3>

Ectopic Pregnancy: Current Treatment Options, deja vu *Humanae Vitae*

by

John E. Foran, M.D.

The author is Coordinator, Internal Medicine Education, Department of Family Medicine, St. Joseph Hospital, Chicago, IL.

Those of us who were practicing medicine in the pre-Vatican II, pre-*Humanae Vitae* 1960s remember well, if painfully, the indecision, rumor and often rancorous debate preceding the definitive instruction of Pope Paul VI's historic encyclical. Even more distressing have been the years of dissent and apathy following its release. A gnawing sense of *deja vu* arises as some of us seek authoritative leadership regarding current toleration of salpinotomy(ostomy) and pharmacologic (methotrexate) treatment of ectopic pregnancy in Catholic health facilities. Though these techniques carry the direct effect of fetal termination, supportive theologians justify these actions under a laudable intention to preserve both the health and fertility of the mother. They argue that traditionally approved total salpingectomy, which entails the removal of the diseased organ with the unintended, though inevitable, death of the fetus, can now often be avoided, thus increasing a woman's chance of future fertility. On the other hand, there are those of us who reason that salpingotomy(ostomy) and medical termination of the conceptus is little more than direct abortion.

It has been a labyrinthine path through "proper channels" on what would seem answerable by basic logic. Departmental, institutional and archdiocesan ethics committees, local Ordinaries, the National Conference of Catholic Bishops (NCCB), the Papal Nuncio and even the Congregation for the Doctrine of the Faith (CDF) have not yet offered effective guidance on this controversy. Not only is the time-honored Principle of Double

(twofold) Effect invoked for and against these actions, but even the pastoral obligation to provide the first sacrament of initiation to Christian life, Baptism, has not been addressed at any level.

The perceived indecision over such critical aspects of reproductive health care eerily parallels the history of "the pill". In 1957 Dr. John Rock, et al,¹ announced development of the oral contraceptive. By 1960, "the pill" had revolutionized sexual behavior worldwide. Not only did this form of contraception contribute immeasurably to so-called sexual freedom, but even faithful Catholic married couples in good, if misinformed, conscience were led to believe that this chemical mode of birth control would be declared morally acceptable by the Church. Teaching authorities from parish to Rome were in debate.

A commission was appointed by Pope John XXIII and later enlarged by Pope Paul VI. Highly respected theologians openly supported change in the interpretation of Church teaching on contraception.² The Vatican Council was called, but had not yet met; the CDF was silent. The commission continued to study the issue. Catholic physicians who denied the legitimacy of pharmacologic contraception found themselves progressively isolated from professional colleagues, in conflict with local clergy and with inevitable loss of patients in their childbearing years. In the vacuum, without vocal theological support or instruction, many Catholic patients and physicians, who would stand firmly opposed to mechanical devices of contraception, found it fully acceptable to embrace "the pill" without a qualm of conscience.

Between 1962 and 1968 the world media reported "leaks" from the commission supporting approval for chemical contraception. The Vatican Council yielded definitive teaching to the Holy Father.³ The horse was out of the barn!

Humanae Vitae,⁴ with its magnificent clarity, was finally released. The joy of the embattled defenders of traditional teaching opposed to artificial birth control was short-lived. Before any opportunity for reflective reading of the encyclical, a widespread attack was renewed with increasing vigor by many theologians of repute. *Humanae Vitae* was released July 25, 1968. On August 4, 1968, Fr. Charles Curran's protest against *Humanae Vitae* appeared as a full-page ad in the *National Catholic Reporter*,⁵ co-signed by a host of distinguished theologians. With few exceptions those loyal to Papal dictum were silent.

Why do I now have a sense of *deja vu*? In January, 1996, I first became aware that, in addition to long-approved total salpingectomy and the more recently developed partial salpingectomy, both medical (methotrexate) and surgical (linear salpingotomy/ostomy) techniques were being utilized in treatment of ectopic tubal pregnancy at our institution, a

Catholic teaching hospital. The ability to make an early diagnosis of ectopic tubal pregnancy in recent years dictates that not only should therapy be directed to preserve the mother's life before rupture of the fallopian tube, but early surgical or pharmacologic intervention could be directed at preservation of fertility. We have long accepted the morality of removal of a diseased fallopian tube to save a mother's life even though the inevitable unintended death of the fetus occurred.

The techniques of salpingotomy(ostomy) and methotrexate treatment, however, raise serious new considerations. Do these procedures, despite good intent, entail direct abortion? Since we know from definitive teaching of the Magisterium that all innocent human life is sacred from the moment of conception, it is apparent that direct abortion is intrinsically evil, anywhere and everywhere a moral evil. Therefore, the question to be resolved is clearly presented in the Ethical and Religious Directives for Catholic Health Care Services (1995).⁶ Directive #45 states "In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion." It further states that "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 can not be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child" (ERD #47). At this point a quick review of the principle of twofold effect may be appropriate. An act which has both a good and an evil effect may be morally justified providing:⁷

- 1) Only the good effect is intended. The evil effect is permitted, but the evil effect is not intended.
- 2) The Act itself is morally good. Taken negatively, the act itself is not evil.
- 3) The good effect precedes (or is simultaneous) with the evil effect. The evil effect cannot cause the good.
- 4) The good effect is at least proportional to the evil effect. The evil effect cannot be greater than the good effect.

To my dismay, respected theologians attempt to apply the principle of double effect to justify these controversial surgical and pharmacologic techniques in the management of ectopi pending definitive instruction from the NCCB or the teaching Magisterium.

Though the carefully structured arguments of Rev. A.S. Moraczewski, O.P.⁸ and the late Fr. John Connery, S.J.⁹ are cited as defending salpingotomy(ostomy), these arguments deserve analysis. Moraczewski avoids discussion of methotrexate as involving "more complicated medical facts" that must be addressed separately. He readily admits that clarification or correction from the teaching Magisterium could modify his analysis of salpingostomy. He then proceeds to defend surgical removal of tissue embedded in the wall of the fallopian tube, extracting "a sizeable amount of tubal tissue" with subsequent repair of the tube thus preserving, hopefully, the woman's fertility. He observes accurately that in addition to removal of the pathological portion of the tube, the embryo is itself also removed, as in total salpingectomy. What Moraczewski defends is not salpingotomy(ostomy) as we shall demonstrate. He confuses the operation of partial salpingectomy with that of salpingotomy(ostomy).

Similarly, Fr. John Connery, S.J., a theologian long admired by this author, describes the surgeon removing part of the tube "to remedy a pathological condition." He clearly rejects "just a separation of the embryo or fetus from its site."

Both theologians recognize the advances in surgical science which allow for preservation of the surgically repaired tube. They fail, however, to recognize the critical distinction between partial salpingectomy and salpingotomy(ostomy). They, in fact, described partial salpingectomy, the removal of the diseased portion of the fallopian tube, rather than dealing with the operation of salpingostomy as described in the obstetrical literature¹⁰: "This technique (salpingostomy) is used to remove a small pregnancy that is usually less than 2cm in length... The ectopic usually will extrude from the incision and can be carefully removed." Salpingotomy is similarly described: "A longitudinal incision is made on the antimesenteric border of the fallopian tube directly over the ectopic. The products of conception are removed with forceps or gentle suction..." These surgical procedures clearly are in contrast to segmental resection and anastomosis of the diseased portion of the fallopian tube. As stated in William's textbook: "This procedure, defined as partial salpingectomy, is recommended for an unruptured ectopic in the isthmic portion of the tube since salpingotomy or salpingostomy likely would cause scarring and subsequent narrowing of this small lumen."

The principle of double effect that Fr. Moraczewski and Fr. Connery carefully applied in their arguments defended justification of partial salpingectomy but was misapplied to salpingotomy(ostomy). This is in contrast to Jean de Blois, C.S.J., et al¹¹ in the reference cited by Rev. Michael Place, then Research Theologian for the Chicago Archdiocese, defending the Chicago Archdiocesan approval of these procedures in

Chicago Catholic health facilities since 1985. De Blois states "The most commonly used conservative intervention is linear salpingotomy. The tube is opened at the site of the unruptured pregnancy and the conceptus is gently detached from the tubal wall and removed. Non-surgical management can be accomplished by use of a drug such as methotrexate...Although the action that corrects the pathology, whether surgical or medical, is the same action that brings about the death of the embryo, that death is not the direct effect that is intended." Frs. Moraczewski and Connery speak of removing the site of the pathology whereas de Blois speaks of "gently" removing the conceptus. Fr. Moraczewski does not address pharmacologic intervention included by de Blois, which she admits is the action causing the death of the embryo. Neither theologian considers the subject of Baptism which I will later mention.

Rev. Msgr. Orvall N. Griese wrote, "The salpingotomy thesis seems to me to depend on showing how we can 'shell out' of the tube but can't do classical abortions; or how the *finis operis* of the two procedures differ essentially, so that one is not the other, irrespective of the *finis operantis* ('motive')." ¹² These matters have been tabled by the NCCB repeatedly. Even the CDF has yet to provide definitive instruction despite the clarity of the *Catechism of the Catholic Church*: ¹³

#2270 – From the first moment of his existence, a human being must be recognized as having the rights of a person...

#2271 – Abortion willed either as an end or a means is gravely contrary to the moral law.

There are no qualifying factors regarding the location of the embryo or its age. It would seem that those medical moralists who would justify linear salpingotomy(ostomy) and pharmacologic means as medical solutions to ectopic pregnancy would have little choice but to justify other means of therapeutic abortion. This concern is borne out as de Blois concludes in her essay *Anencephaly and the Management of Pregnancy* : "It seems that once the diagnosis of anencephaly has been made the pregnancy may be terminated at any time." She further states, "While the mother's life is not in imminent danger, there is the real possibility of maternal harm as pregnancy advances. Since the condition of the fetus deprives it of any potential for development, the proportion seems adequate to justify terminating the pregnancy." ¹⁴ This convoluted application of the principle of double effect carries the distortion of intent and direct effect to another level of confusion when applied to the management of ectopi.

Though most theologians would not apply the principle of double effect so broadly, they do intend the good effects of health of the mother and preservation of fertility (though these good effects might often be served better by partial salpingectomy) as justification for surgical or pharmacologic termination of the fetus. I will not challenge that these good effects are in fact proportional to the evil effect of the death of the fetus, however, the evil effect *is* the direct means to the good effect as in any therapeutic abortion. The direct act of removing the conceptus from the fallopian tube, be it by suction, forceps or toxin, is the cause of the well intended health of the mother. Not "intending" the evil effect does not make the evil effect go away. The good end does not justify the means; the act is evil even though the intention is good. Rev. Patrick Boyle, S.J., professor of moral theology at the University of St. Mary of the Lake, states that those who attempt to justify the act on the grounds that the "fetus is not physically attacked" in the surgical or medical treatment demonstrate a wrong understanding of direct/indirect. He explains in a medical moral bulletin in 1995 that: "Direct and indirect in the principle of double effect do not refer to the physical effect of the action on the object but rather to the immediacy of the effects as they flow from the action." Therefore, since the immediate effect of methotrexate and salpingotomy(ostomy) is the death of the fetus, the principle of double effect is not applicable because the act is evil.

In *The Management of Ectopic Pregnancies: A Moral Analysis*, William E. May points out that "it is morally imperative today to make every effort possible to discover and transplant into the uterus those unborn babies who have, unfortunately, implanted in the fallopian tube or other ectopic site..."¹⁵ He emphasizes that in removal of the diseased organ – be it a fallopian tube in part or in toto, ovary or uterus – the death of the unborn child, even though inevitable, is not the direct effect of the physician's choice. On the other hand, no matter how good the intention, salpingotomy/ostomy and the use of methotrexate or similar pharmacologic agents result in the death of the infant as a direct effect of the action and culminates in the good effect. The death is the means chosen to the end. To willfully choose to terminate innocent human life, no matter how good the intent, is anywhere and everywhere morally wrong.

One further factor, Baptism, makes this issue more complex than that of "the pill". Though repeated requests to hospital ethics committees, hospital chaplains, Archdiocesan theologians, Bishops and Magisterium have been made, no answer has been returned on the need for Baptism. The child dies without Baptism, the first of the sacraments of Christian initiation, unless performed by the very hand that held the forceps or the suction tip. Obviously, no chance was given the necrotic remains of the

fetus before the toxin or pharmacologic termination of its brief life. Does Mother Church wish the conceptus baptized before or after its "gentle removal"? The *Catechism of the Catholic Church* teaches in #1257 "The Lord Himself affirms that Baptism is necessary for salvation." It further states in #1261 "As regards children who have died without Baptism, the Church can only entrust them to the mercy of God..." "Let the children come to me, do not hinder them." Jesus' words are reassuring that the unborn do in fact reach salvation, but is it proper for us, the terminators, to deny the gift of Baptism to the baby when possible? Has the need for Baptism diminished so radically these past thirty years, that it no longer requires consideration? The Catholic Catechism hardly reflects that attitude.

Deja vu? New scientific developments are being applied in Catholic health facilities under the principle of probabilism at least since 1985. Since the NCCB and the Magisterium have not spoken, the assumption of morality has been made. Two distinct camps exist, pro and con. One group of respected theologians supports the actions under the principle of double effect. Another group of respected theologians rejects the actions under the principle of double effect. The Bishops have differing opinions on how the actions are viewed within their individual sees. Some support, some oppose, others remain undecided. Probabilism is applied here, I believe erroneously, to justify a change in interpretation of surgical and medical management of ectopi.

The National Conference of Catholic Bishops has remained unable to reach a consensus despite increasing pressure. Though they wish collegiality and authority, the NCCB refers the issue to the CDF. Appeals from the laity to the CDF are not answered and appeals from the Bishops are answered by NOTA, a communication from the CDF to the local Ordinary, the contents of which remain obscure.

Local hospital ethics committees operate in a vacuum but some take the line of least resistance and follow the proportionalist application of morality. Physicians and their patients are at odds. (Sound familiar?)

The continued delay in definitive teaching on the morality of salpingotomy(ostomy) and pharmacologic interventions in management of ectopic pregnancy already is creating serious problems of conscience for physicians, patients and hospital personnel.

The debate must be brought to a conclusion with unambiguous teaching from the Magisterium.

It is necessary that the NCCB, through its local Ordinaries clearly express the definitive teaching of the Church. It is necessary that Catholic hospitals, their ethics committees and the physicians submit joyously to

their role in the practice of good morals and good medicine. The mistakes following *Humanae Vitae* can be avoided by prompt action.

References

1. Rock, J; Garcia, CM; Pincus, G., Synthetic Progestins in the Normal Human Menstrual Cycle, *Recent Prog Horm Res* , 1957, 13, 323-339.
2. Noonan, John, *Contraception* (Cambridge: Harvard Univ Press, 1965).
3. *The Documents of Vatican II*, (Vatican Council 1962-65) *Gaudium et Spes* 51.
4. *Humanae Vitae* : Pope Paul VI, 1968.
5. *National Catholic Reporter*, August 4, 1968.
6. *Ethical and Religious Directives for Catholic Health Services*, NCCB, 1995.
7. Wuellner, Bernard, S.J., *Summary of Scholastic Principles* (Loyola Univ Press, 1956).
8. Moraszewski, Rev. Albert, O.P., *Managing Tubal Pregnancies P+T*, Pope John Center, 1996.
9. Connery, Rev. John, S.J., *Communication to Msgr. Richard Malone*, 1986.
10. Obstetrics & Gynecology: William, *Williams Obstetrics*, ed. By F. Gary Cunningham, 20th ed., 1997 Appleton Lange.
11. de Blois, J; Norris, P; O'Rourke, K; *A Primer for Health Care Ethics: Essays for a Pluralistic Society*, (Washington, DC: Georgetown Univ Press, xi, 255 p. 23 cm. 1994)
12. Griese, Rev. Msgr. Orville, *Catholic Identity in Health Care: Principles and Practice*, Pope John Center, 1987.
13. *Catechism of the Catholic Church*, Liquori Publications, 1992.
14. de Blois, Jean, C.S.J., *Anencephaly and the Management of Pregnancy*, 1993.
15. May, William E., *The Management of Ectopic Pregnancies: A Moral Analysis: The Fetal Tissue Issue* (Braintree, MA) 1994.