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Sterilization in Catholic Hospitals

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The ethical and religious directives for Catholic Health Care Facilities in the United States (approved by the National Conference of Catholic Bishops in 1971)¹ include the following directives on direct (No. 18) and indirect sterilization (No. 20).

18. Sterilization, whether permanent or temporary, for men or for women, may not be used as a means of contraception.
20. Procedures that induce sterility, whether permanent or temporary, are permitted when (a) they are immediately directed to the cure, diminution, or prevention of a serious pathological condition and (b) a simpler treatment is not reasonably available. Hence, for example, oophorectomy or irradiating of the ovaries may be allowed in treating carcinoma of the breast and metastasis therefrom and orchidectomy is permitted in the treatment of carcinoma of the prostate.

Shortly after the promulgation of the directives, reports began to circulate concerning the formation of multi-disciplinary "sterilization committees" in certain hospitals.² The formation of such committees was justified, in most instances, by an "interpretation" of Directive 20 by a local ordinary and/or theologian. The interpretation had to do with the justification of some direct sterilization procedures through the principle of totality and, to a lesser extent, the adjudication of the licitness of proposed "uterine isolation" techniques.³ Hospitals performing only indirect sterilization procedures such as the orchidectomy and oophorectomy procedures mentioned in Directive 20, did not, in general, see the necessity for forming "sterilization committees."

In the mid-1970s, there arose the spectre of "geographical morality" as most dioceses adhered to the limits of Directive 20, but some did not.⁴ Where bishops allowed the formation of alternate interpretations, they alluded to the fact that Directive 20 was being studied at several levels and being submitted to scrutiny and dissenting theological opinion.

Because of the potential for scandal involved in the geographical variation in the interpretation of Directive 20, the matter was referred to the Sacred Congregation for the Doctrine of the Faith by the U.S. Conference of Catholic Bishops and its then incumbent president, Archbishop Joseph Bernardin of Cincinnati. The questions referred to Rome were those raised by its Pastoral Research and Practices Committee and its chairman, Archbishop John Quinn. The questions had to do primarily with 1) "An expanded notion of the principle of totality" or 2) because so many theologians dissented from the cited reference for Directive 20 ("*Humanae Vitae*" (7/25/68) N.15).⁵

There were four questions which were part of the documentation sent to Rome and the last of these was the crux of the question at hand. "Can we accept the general prohibition of direct sterilization in Catholic hospitals and still make a number of exceptions in particular cases to solve pastoral problems?" The response to the questions from the NCCB was issued by the Vatican's Doctrinal Congregation on March 13, 1975 and was remarkably forthright and unambiguous as is evident from the following direct quotations.⁶

1) Any sterilization which of itself, that is, of its own nature and conditions, has the sole immediate effect of rendering the generative faculty incapable of procreation is to be considered direct sterilization as the term is understood in the declarations of the pontifical magisterium, especially of Pius XII. Therefore, notwithstanding any subjectively right intention of those whose actions are prompted by the care or prevention of physical or mental illness which is foreseen or feared as a result of pregnancy, such sterilization remains absolutely forbidden according to the doctrine of the Church. And indeed the sterilization of the faculty itself is forbidden for an even graver reason than the sterilization of individual acts, since it induces a state of sterility in the person which is almost always irreversible.

Neither can any mandate of public authority which would seek to impose direct sterilization as necessary for the common good be invoked, for such sterilization damages the dignity and inviolability of the human person. Likewise, neither can one invoke the principle of totality in this case, in virtue of which principle, interference with organs is justified for the greater good of the person. Sterility intended in itself is not oriented to the integral good of the person as rightly pursued "the proper order of goods being 'preserved' inasmuch as it damages the ethical good of the person, which is the highest good, since it deprives foreseen and freely chosen sexual activity of an essential element. Thus article 20 of the medical-ethics code promulgated by the Conference in 1971 faithfully reflects the doctrine which is to be held and its observance should be urged.

2) The congregation, while it confirms the traditional doctrine of the Church, is not unaware of the dissent against this teaching from many theologians. The congregation, however, denies that doctrinal significance can be attributed to this fact, as such, so as to constitute a "technological source" which the faithful might invoke and thereby abandon the authentic magisterium and follow the opinions of private theologians which dissent from it.

3) Insofar as the management of Catholic hospitals is concerned:

1) Any cooperation which involves the approval or consent of the hospitals to actions which are in themselves, that is, by their nature and condition, directed to a contraceptive end, namely, in order that the natural effects of sexual actions deliberately performed by the sterilized subject be

impeded, is absolutely forbidden. For the official approbation of direct sterilization and, *a fortiori*, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil. The Catholic hospital cannot cooperate with this for any reason. Any cooperation so supplied is totally unbecoming the mission entrusted to this type of institution and would be contrary to the necessary proclamation and defense of the moral order.

Following the release of the above Vatican document, Archbishop Bernardin, as president of the NCCB-USCC wrote a letter addressed to all of the U.S. hierarchy which concluded, in part, "I am writing to give assurance that the 1971 guideline stands as written and that direct sterilization is not to be considered as justified by the common good, the principle of totality, the existence of contrary opinion, or any other argument. This means that Catholic hospitals, as a matter of institutional policy, may not authorize sterilization procedures for reasons other than those contained in the guidelines."⁷ A further clarification was issued by the NCCB on July 9, 1980 as follows:

Statement on Tubal Ligation

Since we note among Catholic health care facilities a certain confusion in the understanding and application of authentic Catholic teaching with regard to the morality of tubal ligation as a means of contraceptive sterilization (cf. nos. 18 & 20, "Ethical and Religious Directives for Catholic Health Facilities") the National Conference of Catholic Bishops makes the following clarification:

- 1) The traditional teaching of the Church as reaffirmed by the Sacred Congregation for the Doctrine of the Faith on March 13, 1975 clearly declares the objective immorality of contraceptive (direct) sterilization even if done for medical reasons.
- 2) The principle of totality does not apply to contraceptive sterilization and cannot be used to justify it.
- 3) Formal cooperation in the grave evil of contraceptive sterilization, either by approving or tolerating it for medical reasons, is forbidden and totally alien to the mission entrusted by the Church to Catholic health care facilities.
- 4) The reason for justifying material cooperation as described in the NCCB Commentary on the SCDF response refers not to medical reasons given for the sterilization but to grave reasons extrinsic to the case. Catholic health care facilities in the United States complying with the "Ethical and Religious Directives" are protected by the First Amendment from pressures intended to require material cooperation in contraceptive sterilization. In the unlikely and extraordinary situation in which the principle of material cooperation seems to be justified, consultation with the Bishop or his delegate is required.
- 5) The local Ordinary has responsibility for assuring that the moral teachings of the Church be taught and followed in the health care facilities which are to be recognized as Catholic. In this important matter there should be increased and continuing collaboration between the Bishop, health care facilities and their sponsoring religious communities. Local conditions will suggest the practical structures necessary to insure this collaboration.
- 6) The NCCB profoundly thanks the many physicians, administrators and personnel of Catholic health care facilities who faithfully maintain the teaching and practice of the Church with regard to Catholic moral principles.

The explicit and detailed nature of both the Sacred Congregation's statement and the NCCB directive would be expected to foreclose the issue of direct contraceptive sterilization in Catholic hospitals. Two areas of contention persisted, however, and have not been resolved to everyone's satisfaction. These are 1) the limits of acceptable material cooperation⁸ and 2) the alleged licitness of certain sterilization procedures known generally as "uterine isolation".⁹

Material Cooperation

The debate concerning the legitimate material cooperation was occasioned by a paragraph in the text of the Doctrinal Congregation's statement on sterilization which read as follows:

"b) The traditional doctrine regarding material cooperation with the proper distinctions between necessary and free, proximate and remote remains valid to be applied with the utmost prudence if the case warrants.

c) In the application of the principle of material cooperation, if the case warrants, great care must be taken against scandal and the danger of misunderstanding by an appropriate explanation of what is really being done." The Bernardin letter to Catholic health facilities paraphrased this statement as "If questions of material cooperation arise, the traditional norms of moral theology are to be applied."

Some theologians seized upon the Sacred Congregation's phrase, "any cooperation which involves the approval or consent of the hospital" as indicating that the congregation intended to disapprove only *formal* cooperation in sterilization procedures.¹⁰ It was alleged that a hospital might allow sterilization to be performed on its premises while withholding approval or consent to the procedure. In the real world of hospital practice, however, it is not possible to have performed on a hospital's premises any surgical procedure not approved by the bylaws, rules and regulations of the hospital medical staff and its board of trustees. To suggest that a hospital might somehow consent juridically to the performance of a surgical procedure, while at the same time withholding approval of the morality of the procedure, would be a strained and casuistic application of the principles of material cooperation.¹¹

Other theologians have treated the question of licit application of the principles of material cooperation in a contrasting manner.¹² While the concept of cooperation or complicity in the evil deed of another is ancient, more precise terms regarding cooperation are usually traced to St. Alphonsus, as follows:¹³

In *explicit formal* cooperation, the cooperator intends the evil, as does the primary agent. In *implicit formal* cooperation (also known as *immediate material* cooperation), the cooperator does not intend the evil, but supplies cooperation without which the evil act cannot be accomplished. Neither of the aforesaid types of cooperation (explicit formal and implicit formal/immediate material) is allowable.

Mediate material cooperation would be decided on a case by case basis. Repeated proximate cooperation would not be likely to be approved. Single episodes of remote material cooperation were more likely to be acceptable. The treatment of material cooperation by approved theological sources applied to individuals and not to institutions. Is there any situation in which a Catholic institution might allow direct contraceptive sterilization on its premises? Smith suggests the following unlikely scenarios:¹⁴

- 1) The hospital is coerced by a one-instance court order.
- 2) A surgeon, without warning, does a procedure contrary to the policy of the institution. Personnel might cooperate to avoid a greater evil of serious injury to the patient.

The above instances would be construed as illicit coercion in which licit material cooperation could be justified. There are probably no licit applications of material cooperation in direct sterilization in a Catholic hospital. McCormick has suggested that the restrictions against sterilization in Catholic hospitals are too stringent.¹⁵ "If not every killing is wrong," he asks "why is every sterilization wrong?" To this, Connery responds that not every sterilization is wrong.¹⁶ Indirect sterilization, like indirect killing is morally permissible; sterilization in self-defense can be justified and punitive sterilization, like capital punishment, has never been condemned in theory. Human life and the sources of human life have been associated throughout history. In Roman law, the life-giving power was given the same protection as life itself. The life-giving power was and is considered sacred because life itself is sacred.

Uterine Isolation Procedures

The proposition upon which arguments in justification of so-called "uterine isolation" procedures is based can be summarized as follows:¹⁷

- 1) It is possible for a uterus to be so damaged by repeated Caesarean sections that it cannot be adequately repaired to support safely another pregnancy.
- 2) The dangerously pathological uterus could legitimately be removed the same as any other pathological organ. The damage in the uterus itself constituted a legitimate application of the principle of totality.
- 3) The sterility thus produced would not be directly intended but rather a legitimate indirect by-product under the principle of double effect.

The issue was debated over time with Father Gerald Kelly arguing in favor of hysterectomy as indirect sterilization and Father Francis Connell viewing the surgery as directly contraceptive.¹⁸ Father Kelly's opinion

came to be viewed as solidly probable and safely to be followed in practice. Thus Directive 22 in the Ethical and Religious Directives for Catholic hospitals reads as follows:

22. Hysterectomy is not permitted as a routine procedure after any definite number of Caesarean sections. In these cases, the pathology of each patient must be considered individually and care must be had that hysterectomy is not performed as a merely contraceptive measure.

Meanwhile another moral aspect of the same case of the damaged uterus was being explored by Thomas O'Donnell, S.J.^{19,20} The question under investigation was whether, in the event that the clinical condition of such a patient contraindicated further surgery (hysterectomy) at the time of Caesarean section, the surgeon might legitimately "isolate" the uterus at the tubal adnexa. Such "isolation" was to be viewed as the less dangerous "first stage" of a legitimate hysterectomy for a uterus irreparably damaged by repeat Caesarean sections. If hysterectomy was not directly contraceptive, then "isolation" of the uterus at its adnexa (instead of extirpation of the uterus when clinically indicated) would also not be directly contraceptive.

The rationale for the argument is that there is no moral difference between thus isolating the uterus and removing it. It was pointed out that part of the surgical technique of hysterectomy consists in the clamping and cutting of the Fallopian tubes in the process of freeing the uterus. When this has been done, the damaged uterus has already been functionally isolated. At that point, one has already passed through the moral issue involved. Whether or not the uterus is now actually removed from the pelvic cavity is without moral significance.

In a cogent criticism of this rationale, Hilgers states:

While it is true to say that clamping, ligating, and cutting the fallopian tubes is part of an abdominal hysterectomy (assuming that the tubes and ovaries are left in) I do not believe that it follows that, in effect, tubal sterilization is simply the beginning part of a hysterectomy and can be stopped at that point. A hysterectomy is an operation of and by itself. If one cuts, ligates and divides the fallopian tubes, one is doing a tubal ligation. One is not doing a hysterectomy or the first part of a hysterectomy. I believe that it is somewhat semantic gymnastics to call 'uterine isolation' anything but a tubal ligation.²¹

This is further reinforced by the knowledge that the medical literature lists as the indications for the majority of Caesarean hysterectomies, either elective or emergency, the following: placenta accreta, previa accreta, previa or abruptio plus post-partum hemorrhage, atony or uterine artery laceration at Caesarean section, cervical intraepithelial neoplasia, micro-invasive carcinoma, broad ligament hematoma, fibroids, infection or disseminated intravascular coagulopathy. Virtually none of these would be corrected by "uterine isolation" and so it would be dishonest to describe tubal ligation as the "first stage" of Caesarean hysterectomy.

If we accept the moral reasoning as sound, then the question arises as to how often, if ever, the "uterus irreparably damaged by Caesarean section"

is clinically verifiable. It should be noted that, at the time the theological debate was going on, the procedure of choice was the classical Caesarean section. The lower transverse procedure now preferred by most obstetricians would be expected to produce less damage in repeated sections. Even when the classical procedure was preferred, an extensive study failed to show a greater risk of rupture following a sixth Caesarean section as compared to the second.²² Navekar has pointed out that the mortality of a ruptured Caesarean section scar is not greater than that associated with routine repeat sections.²³ Donnelly reported that while the maternal mortality associated with 58 uterine ruptures was 21%, no deaths occurred among women whose ruptures were in Caesarean section scars.²⁴ In a comprehensive study, maternal mortality figures of 20-70% with traumatic and spontaneous rupture are in marked contrast to the 1% mortality associated with the rupture of a previous Caesarean section incision.²⁵ Miller, et al, in reviewing 1,462 repeated sections, described the maternal mortality as "indeed minimal."²⁶ Three reports in the literature would seem to confirm this optimistic outlook.^{27, 28, 29} The definition used for uterine rupture is important. A scar is considered intact regardless of its width or thickness if the edges of the myometrium are in complete apposition.³⁰ The presence of a thinned lower segment does not indicate impaired integrity of the scar or impending rupture.

As Hilgers has remarked, "At the time of Caesarean section, if the previous scar has either ruptured or dehisced the scar can be revised and repaired at the time of that Caesarean section leaving the uterus in an acceptable position to sustain a subsequent pregnancy."³¹ Klaus, speaking from seven years experience as chief of an obstetrical service in Pakistan, rejects the notion that uterine isolation would be the procedure of choice even in developing countries.³² She states that "There is no uterine pathology which could be alleviated or cured by ligating the tubes" and "when the uterus is so badly ruptured that it cannot be repaired, it should be removed."

In a comprehensive 15-year study, Brennan could find no support for the notion that ruptured scars after repeated Caesarean sections contributed significantly to maternal or infant mortality.³³ Several authors have pointed out that hysterectomy may be required in one-third or more women who had a previous tubal ligation because of menorrhagia, dysmenorrhea and dyspareunia.^{34, 35}

More important, when an experienced panel of medical authorities was polled on the specific issue of "uterine isolation" at the time of discovery of a ruptured uterus during the performance of a Caesarean section:

71.4% of respondents denied that uterine isolation would significantly reduce risk as compared to a completed hysterectomy.

80.4% preferred hysterectomy as the procedure of choice as compared to only 6.5% who would prefer uterine isolation even if the bladder were incorporated in the scar.

67% of those asked to characterize the "uterine isolation" procedure described it as "direct contraceptive sterilization" and only 33% as "indirect sterilization".

87% of respondents denied that tubal ligation was an accepted medical treatment for any disease (excluding diseases aggravated by pregnancy where the purpose of tubal ligation is to prevent pregnancy).³⁶

If one accepts the legitimacy of "isolating" the uterus at the tubal adnexa at surgery, would "isolation" not be similarly achieved by a diaphragm, a cervical cap, or by sialastic implants in the ostia of the fallopian tubes?³⁷ All of these procedures would be clearly contraceptive in intent but no less capable of producing a state of uterine "isolation." Do such clinical data not erode the legitimacy of uterine isolation as an *indirect* rather than a *direct* sterilization?

In summary, the concept of irreparable uterine damage occasioned by repeated Caesarean section is of diminishing validity in modern obstetrics. In the uncommon instances where it might be validated, hysterectomy would be the procedure of choice. There is very little support for the suggestion that "uterine isolation" would be preferred or that it would be less risky than hysterectomy. As O'Donnell, the principal proponent of the moral licitness of uterine isolation has pointed out:

The sad sequel to all of this was that the term: 'isolation of the uterus' had taken root in the medical-moral community and, either through misunderstanding or deception, was being used as a presumably morally acceptable semantic for various forms of clearly contraceptive sterilization. This is an error which still persists in some quarters.³⁸

The concept of uterine isolation was specifically eliminated from Directive 22 on hysterectomy because of its potential for abuse and the requirement for detailed moral catechesis to understand its very limited application. With the passage of time and the improvement of obstetrical techniques, it is difficult to support the concept as clinically realistic or applicable.^{39,40} There is strong medical evidence that the procedure can only be properly understood as directly contraceptive.⁴¹ For a physician to apply the term "uterine isolation" (a theological as well as surgical concept) to a directly contraceptive tubal ligation when pregnancy is judged to be clinically contraindicated for other reasons (e.g., cardiac pathology or psychiatric disturbance) is either morally ignorant or intentionally devious.⁴²

Direct sterilizations do not treat any disease but rather have a contraceptive purpose. Tubal ligations are performed for the precise purpose of destroying the procreative function. It is difficult to understand how the increased availability of procedures to destroy the reproductive function can be held out as a way for Catholic hospitals to promote their obstetrical departments.

References

1. NCCB, Ethical and Religious Directives for Catholic Health Facilities (Washington, D.C. USCC 1971).

2. "Sterilization:" Hospitals Dodge Ban? *National Catholic Reporter*, 13:45, 1977.
3. "Sterilization in Catholic Hospitals," *Origins*, 7:399, 1977.
4. Zimmerman, A. "Sterilization for Contraceptive Purposes in Catholic Hospitals." *Homiletic and Pastoral Review*, June 1978 p. 56-63.
5. Paul VI, Encyclical *Humanae Vitae* AA560, 1968.
6. "A Document about Sterilization in Catholic Hospitals," Sacred Congregation for the Doctrine of the Faith, March 13, 1975.
7. Letter to American Bishops from Most Rev. Joseph Bernardin, President, NCCB-USCC, September 1977.
8. O'Rourke, K.D. "An Analysis of the Church's Teaching on Sterilization," *Hospital Progress*, 57:68, 1976.
9. O'Donnell, T., "Uterine Isolation" *Medical Moral Newsletter*, 16:8, 1979.
10. McCormick, R., Letter to the Editor; *Linacre Quarterly*, May, 1977.
11. Paganelli, V. "An Update on Sterilization," *Linacre Quarterly*, 14:12, 1977.
12. Smith, W., "Catholic Hospitals and Sterilization," *Linacre Quarterly*, 14:107, 1977.
13. O'Donnell, T., *Medicine and Christian Morality*, Alba Press, New York, 1976, p. 31-38.
14. Smith, *op. cit.*
15. McCormick, R. and Bayley, C., "Sterilization: The Dilemma of Catholic Hospitals", *America*, Oct. 18, 1980.
16. Connery, J. *Fellowship of Catholic Scholars' Newsletter*, 4:10, 1980.
17. O'Donnell, T., "Uterine Isolation", *op. cit.*
18. *Ibid.*
19. Smith, *op. cit.*
20. O'Donnell, T., *Medicine and Christian Morality*, *op. cit.*
21. Hilgers, T., "Uterine Isolation - 20 Years Later" *Medical-Moral Newsletter*, 24:17, 1987.
22. Prem, K., University of Minnesota School of Medicine, personal communication.
23. Narvekar, M., "Labor Following Previous Caesarean Sections", *J. Obstet and Gynaec, India*, 7:115, 1956.
24. Donnelly, J. Remarks, *American Journal of Obstetrics and Gynecology*, 70:91, 1955.
25. Miller, P. et al., "Repeat Caesarean Section", *American Journal of Obstetrics and Gynecology*, 81:867, 1961.
26. *Ibid.*
27. McNally, H. and Fitzpatrick, V., "Patients with 4 or More Caesarean Sections", *Southern Medical Journal*, 54:360, 1961.
28. Paquin, J., "Multiple Caesarean Sections", *Medical Ann. D.C.*, 32:170, 1963.
29. Tepedino, M. et al., "Multiple Caesarean Sections", *American Journal of Obstetrics and Gynecology*, 85:250, 1963.
30. Pedowitz, P. and Schwartz, R.M., "The True Incidence of Silent Rupture of Caesarean Section Scars", *American Journal of Obstetrics and Gynecology*, 74:1071, 1957.
31. Hilgers, *op. cit.*
32. Klaus, J., Comment on reference #17 - personal communication.
33. Brennan, J. and Fons, J., "Multiple Caesarean Section", *Obstetrics and Gynecology* 28:287, 1967.
34. Neill, J.R., et al., "Late Complications of Sterilization", *Lancet*, 2:699, 1975.
35. Nobel, A.D., "Sterilization, Laparoscopy and Laparotomy", *British Medical Journal*, 4:227, 1975.
36. Diamond, E., "Clinical Medico-Moral Issues Regarding Sterilization", *Linacre Quarterly*, 12:6, 1975.
37. McNally and Fitzpatrick, *op. cit.*
38. O'Donnell, T., "Uterine Isolation", *op. cit.*
39. Bayer, E., "Isolating the Threatening Womb", *Ethics and Medics*, 10:2, 1985.
40. Bayer, E., "To Tie or Not to Tie", *Ethics and Medics*, 11:9, 1986.
41. Diamond, *op. cit.*
42. O'Donnell, T., personal communication.

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