Ectopic Pregnancy: A Theological Review

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great abyss which separates men from heaven. Only through Christ can we become Christians. Only through Christ can we become acceptable to God. Only through Christ can we work for an eternal reward. And only in Christ will men find the love that transcends, but does not abstract from, their differences in order to bind them into a fellowship in Christ Our Lord.

PLEA FOR MEDICAL VOLUNTEERS

Last March the Catholic Medical Center in Seoul, Korea, graduated its first class of 39 doctors. This institution founded in 1954 is the only medical college under Catholic auspices on the entire continent of Asia. During this past year Father Peter Ryang, Director, received 2,400 applications for the 70 openings in its PreMed class. The entire student body totals 390.

The great aim at present is to build up medical standards in this hospital and school, which has a decisive influence on medical standards throughout the country. Right now there is a special need for several well qualified American doctors, lab technicians, a dietician and a dentist who could spare from 6 months to two years to upgrade staff doctors and nurses on latest medical techniques and drugs.

Any qualified person, with the time and generosity to help this epochal venture, may learn full details by writing to:

FATHER PETER RYANG
CATHOLIC MEDICAL CENTER
MYONG-DONG
SEOUL, KOREA

Ectopic Pregnancy: A Theological Review

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THE MORAL PRINCIPLES

For one who by avocation is more or less habitually itinerant on the medico-moral circuit, it does not take long to discover that among the more difficult topics to refine in one's own theological thinking — and, a fortiori, to communicate intelligently and intelligibly to others — is our moral doctrine regarding surgical intervention in the event of ectopic pregnancy. Both medically and morally the problem is extremely exasperating, as obstetricians and theologians will ruefully confess. Consequently, the comments which now follow are not presumptuously designed to belay the odious spectre beyond all probability of its haunting us again in the future. Rather they are intended only to refocus attention upon certain immutable principles which must be respected if the medical complications of ectopics are to be solved in accordance with sound morality. Perhaps re-emphasis in that direction may at least serve to admit an additional watt or two of the medico-theological light which began to illumine this question some thirty years ago when Father Bouscaren published his invaluable dissertation on the subject.\footnote{1} The direct killing of any innocent person is always morally wrong. Any procedure whose sole immediate effect is the death of a human being is a direct killing. Every unborn child must be regarded as a human person, with all the rights of a human person, from the moment of conception.

Accordingly it follows that no complication of pregnancy, however discussed in the medical and religious journals, does not raise the moral question of whether an innocent human life is saved or destroyed. This is the question which, in the light of our directives of June 15, 1956 (the directives to which I shall henceforth refer), must be the criterion of all medical decisions in such a case. For example, consider the actual operation performed on the patient in question by Dr. Y. and Dr. Z. The direct killing of any innocent person is always morally wrong. Any procedure whose sole immediate effect is the death of a human being is a direct killing.


2 Ethical and Religious Directives for Catholic Hospitals (St. Louis: Catholic Hospital Association, 1959).
ever perilous to maternal life, may
clearly be resolved by any pro-
cedure which entails direct assault
upon a living fetus. And this
natural-law prohibition would ob-
tain even though it could be al-
together certain that a given fetus
was doomed to natural death be-
fore ever reaching viability. Fetal
life is ever and always innocent
life, morally immune from direct
attack on the part of any human
agent. Or as Directive 15 ex-
presses it,

Direct abortion is never permitted, even
when the ultimate purpose is to save the
life of the mother. No condition of preg-
nancy constitutes an exception to this
prohibition. Every procedure whose sole
immediate effect is the termination of
pregnancy before viability is a direct
abortion.

Maternal life, however, is equally
as sacred and no less privileged,
and is never to be wantonly sacri-
ficed. When threatened by disease
or organic dysfunction, an expect-
ant mother, no less than her un-
born child, has a right to be pro-
tected by every reasonable and legitimate
means at her doctor's
and he is never to be wantonly sacri-
flced. When threatened by disease
or organic dysfunction, an expect-
ant mother, no less than her un-
born child, has a right to be pro-
tected by every reasonable and legitimate
means at her doctor's
disposal. While it cannot be
granted that new-born child, has a right to be pro-
tected by every reasonable and legitimate
means at her doctor's
disposal. While it cannot be
granted that

Risk to life and even the indirect threat
of life are morally justifiable to
proportionate reasons. Life is taken
directly only when death is the unavoidable
consequence of a procedure which
is immediately directed to the
removal of a diseased organ.

Or as Directive 16 states in more
specific terms of obstetrical
complication,

Operations, treatments, and procedures
during pregnancy which have as their
immediate purpose the cure of propor-
tionately serious pathological condition of
the mother are permitted when they cannot
be safely postponed until viability is
attainable, even though they indirectly cause
an abortion.

It is on the basis of these several
moral principles that theologians
must proceed when confronted
with the question of ectopic preg-
nancy. Mindful of the fact that
all human fetal life is innocent
human life, there remains no theo-
 logical choice but to condemn any
and all procedures which involve
direct feticide. And in order to
find justification for other pro-
cedures which only indirectly though
inevitably result in fetal death,
the moralist must satisfy himself
(1) that the treatment's ques-
tion is aimed at the cure or con-
trol of some pathological condition
distinguishable from the pregnancy
itself, and (2) that sufficiently
serious reason can be adduced for
permitting the death of the fetus.
Thus the question at the moment
is: Can these facts be verified
in at least some cases of ectopic preg-
nancy?

THE MEDICAL PICTURE

It would be superfluous—and, for a theologian, presumptuous as
well—to attempt to

LINACRE QUARTERLY

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be directed not to the death of the inviable fetus but to the removal of malignancy. In other words, we are safely within the ambit of Directives 13 and 16 which acknowledge the licitness in some circumstances of certain procedures which involve serious risk to, or even destruction of, fetal life.

THE PRINCIPLES APPLIED

How would these Directives apply to measures commonly used when tubal pregnancy is detected? For the sake of clarity it may be helpful to distinguish between those procedures upon which there is total agreement among theologians and those about which some dispute still exists.

1. Moralists unanimously concede, first of all, that after tubal rupture has occurred, the doctor not only may but should clamp off the maternal arteries from which the hemorrhaging proceeds and excise the damaged tube. It is eminently clear that in these circumstances fetal death either has already occurred or else will be the indirect result of measures which are necessary if the mother’s life is to be saved. Indisputably the hemorrhage is a pathological entity physically distinct and separable from the embryo, whether dead or alive, and as such cannot be justified. And this conclusion obtains even if the purpose of so proceeding is to repair the tube and preserve it for generative function in the future. In paraphrase of Directive 15, one might say in this context: "Direct abortion is never permissible, even when the ultimate purpose is to salvage a generative organ for a subsequent pregnancy.”

2. There is likewise agreement that if, prior to tubal rupture, incision is made in the tube and a living, inviable fetus extracted, this procedure certainly constitutes a direct attack upon human life and its survival: either the fetus already is dead but to the death of the inviable fetus; or it is alive and merely requires to be delivered. The reason for so proceeding is clear: it is necessary in order to save the mother. Consequently, measures which involve serious risk to, or even destruction of, fetal life are licit.

3. By far the majority of theologians at present are persuaded that, even before ultimate rupture of the tube, not all surgical intervention is precluded. They base their opinion ultimately on the medical fact already emphasized, viz., the pathological state of the organ even antecedent to rupture. If in the considered judgment of the physician damage to the tube is such that further delay in removing it threatens serious danger to the mother, then the tube may be excised, as might malignancy, even though concurrently the fetus is deprived of life.

This last conclusion, which beyond all doubt is tenable both in theory and in practice, is not one to be applied thoughtlessly. It remains the responsibility of the physician to determine in individual cases whether or not threat to maternal life is here and now such that expectancy treatment is positively contraindicated. Usually, it would seem, when tubal pregnancy has been diagnosed by reason of characteristic symptoms, the tube is already so damaged as to represent serious danger to the mother. But to the reasonable best of the doctor’s ability this presumption should be verified in each instance before recourse is had to salpingectomy.

Consideration should also be taken — at least theoretically — of the very exceptional case in which tubal pregnancy is discovered when close to viability. Because of the greater likelihood in these circumstances that fetal life can be safely prolonged until extrauterine existence is possible, expectancy treatment is morally justified unless it is clear that even relatively short a delay would be perilous for the mother.

SECONDARY ABDOMINAL PREGNANCY

A further complication may develop if, despite tubal rupture, the fetus survives and continues to evolve in the abdominal cavity with placental attachment to some adjacent organ. From the relevant medical literature one gets the impression that in this eventuality some doctors prefer — and this in primary terms of maternal health — to let nature take its course until the fetus either dies a natural death or attains viability. But abdominal pregnancy is not always that uneventful. There may occur hemorrhage requiring immediate remedial measures. Maternal viscerae may be seriously damaged by the parasitic fetus and demand repair without delay. What, if anything, may be done to alleviate such complications as these?

Speculatively the principles to be employed here are exactly the same as those already applied to the tubal pregnancy: a universal prohibition against direct assault upon fetal life, even as a means to a most laudable end; and the legitimate concession that a pathological condition may be treated, if necessary, by measures which incidentally result also in death for the fetus. But at the practical level we have to face the seeming fact that it is relatively difficult to construct a realistic obstetrical case of this kind in which surgical intervention would be advantageous to the mother without at the same time being directly fatal to the fetus. Difficult, but not impossible.

Serious hemorrhage may licitly be checked by means of any necessary hemostatic measure which is not immediately directed against the fetus, even though indirectly the procedure may dislodge the fetus. By the same token, dangerous impairment of maternal organs may be corrected by any effective and necessary means which are not directly feticidal. It is the prerogative and responsibility of doctors to propose specific remedies which qualify under those restrictions.
SUMMARY

The foregoing comments represent nothing more than a standard synopsis of current theological teaching on the question of ectopic pregnancy. Emphasis has been placed on the basic moral principles on which that teaching depends, in the hope that certain misconceptions of our position may thereby be corrected. Only a proper understanding and appreciation of those fundamental norms will make it possible to perceive the total significance of the practical conclusion expressed in Directive 20:

In extrauterine pregnancy if a part of the mother (e.g., an ovary or fallopian tube) may be removed, even though the life of the fetus is directly terminated, provided the operation cannot be postponed without notably increasing the danger to the mother.

The Physician Who Became Pope

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By MODERN standards, the transformation of a successful practicing physician into a pope is almost unthinkable. Yet this is precisely what happened in the thirteenth century when the renowned Petrus Hispanus exchanged his scalpel for the papal ring and keys to become Pope John XXI.

It must be remembered that the thirteenth century was a period of intellectual awakening that marked the beginnings of the Renaissance. One of the characteristics of the period was its union of medicine and theology, due chiefly to the fact that virtually all learning for centuries had been in the hands of the clergy.

Petrus was born in Lisbon between 1210 and 1220. Little is known of his early life. He was the son of a Lisbon physician, Julianus. He first appeared as a student at the University of Paris. There, as a fellow student of Roger Bacon, he came under the influence of the great logician, William Shyreswood.

As medicine was not then sharply separated from the other branches of philosophical learning, it was not abnormal for Petrus to pass from the logic of Aristotle and the Arabian philosophers to medicine.

During the middle of the thirteenth century Petrus was a teacher of medicine at Siena when the ambitious town was about to establish its own university. It was here that he wrote his first medical work, "A Dietetic Treatment of Surgical Patients," at the request of his colleague, a surgeon, John Mordentis of Faenza.

Before his election to the papacy, Petrus had become not only a high church dignitary but a popular and famous practicing physician. His name was a medical household word in the middle ages.

An Italian, Ottoboni Fleschi, Pope Adrian V, was the preceding pope. Adrian had suffered so much during his election at the conclave supervised by Charles of Anjou that he lived only 38 days as pope and died at Viterbo, August 18, 1276.

A new conclave was assembled at once. Because of the hot weath-